

WINDMILL 2009

NHS response to the financial storm

Sarah Harvey, Alasdair Liddell, Laurie McMahon

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windmill
2009
THE STORM SCENARIO

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Sarah's interests include strategy development, service reconfiguration and improvement and futures studies. She enjoys designing processes that bring together people with diverse interests. Sarah also helps boards, partnerships and alliances in developing effective governance and working relationships. As a consultant, Sarah has worked with groups at all levels in the health industry from primary care practices and collaboratives to the NHS Executive, Department of Health, strategic health authorities, primary care trusts, trusts and multi-agency partnerships.

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In 1994 he joined the Department of Health as Director of Planning for the NHS, where he had board-level responsibility for NHS planning and priorities, information and IT in the NHS, primary care, pharmaceutical services and communications. He led the teams working on The New NHS 1997 White Paper and the Information for Health review of the NHS information strategy, and was responsible for the development and launch of NHS Direct and NHS Direct Online. He was a member of the top management board of the NHS for 12 years.

He left the Department of Health in 2000 to help set up a new media company, and now works as an independent consultant, specialising in health and communications strategy, system reform, and health technology.

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Foreword

The health service is about to enter a new era. After years of unprecedented growth, it faces the prospect of unprecedented austerity. Many of those responsible for running and paying for local health care services are aware that the good times are coming to an end, yet, understandably, there is uncertainty about the nature and extent of the challenges ahead.

The global recession has hit the British economy hard, and government borrowing is at an all-time high. Unemployment is rising and large swathes of the private sector have suffered significant losses. Thus far, the public sector has been protected by previous commitments, and by the decision to use government spending to prevent a deeper recession.

This situation will not last. A recent report from The King's Fund and the Institute for Fiscal Studies suggests that even if the next government commits itself to 'protect' NHS spending, the room for manoeuvre will be very limited (Appleby *et al* 2009). Given rising demand and expectations, there will be little choice but to make significant savings.

The big question is how will the NHS respond? Unemployment and other by-products of the economic downturn will take their own toll on the health of the nation. Many of those responsible for the service today only have experience of running organisations during times of plenty. The traditional safety valves of longer waiting times for operations and procedures are no longer acceptable responses.

The official line, largely shared by government and opposition, is plausible but optimistic. It points out that the extra funding will not disappear overnight and that the health system should be able to cope with greater demand if it is managed more effectively. It also suggests that tougher times can be used as a catalyst to drive quality and productivity: through cost improvement programmes, adopting innovative practices and embracing technology. Others fear that less spending power will necessitate some form of rationing or restriction in services.

In either case, however, it is clear that the normal process of delivering NHS 'efficiencies' will not be enough. Given the scale of the savings that need to be made, doing a bit more of the same is not a viable option. There is a need in each area for a radical step change in how services are provided, where, and to whom. Anything less, and it is difficult to see how we can sustain the quality of care and the access to services that patients currently enjoy.

This was the context that prompted us to run another Windmill simulation. The first Windmill events, held in the early 1990s, were an attempt to understand how a new system with purchasers and providers would operate in practice. The idea was revived two years ago in Windmill 2007, when we used a behavioural simulation to explore how the health system might develop with the systems and incentives around at that time. The resulting report struck a chord with many and clarified key policy questions (Harvey *et al* 2007).

Since then, however, the outlook has darkened considerably, and we felt it would be useful to use the same approach to test how the various players in and around the health care system would respond to this very different scenario. Windmill 2009 provides some key lessons for policy-makers, commissioners and providers.

As in 2007, the Windmill simulation was designed and facilitated by Laurie McMahon and Sarah Harvey of Loop2, and led by Alasdair Liddell, a Senior Associate here at the Fund. We are enormously grateful to them for their expertise and their commitment to the project. But the success of the Windmill process also relies heavily on the experience and judgement of the participants – those who work in and use the health care system. I would, therefore, like to pay tribute to all those who took part in the simulation, including those who contributed to the moderation sessions or in other ways helped to craft the final product.

I believe this is a powerful and timely report. Important decisions will have to be made at different levels of the system – and each one will shape the health service of the future and help to determine whether or not it can survive and thrive. There are fundamental issues that need to be addressed: the way incentives are placed in the system, as well as the balance between choice, competition and diverse provision, on the one hand, and the degree of central planning and control, on the other. Likewise, we need to understand how far and how quickly the system can move to provide patients with more integrated care, in a way that overcomes the current gap between primary and secondary provision and the divide between health and social services.

In the last couple of years, there has been a greater effort to involve and engage clinicians, and with it, a greater focus on the quality of care and improving the patient experience. It is now more vital than ever that this shared commitment – to ensuring that services are safe, effective, patient-centred, timely, efficient and equitable – is sustained and strengthened (Institute of Medicine 2001).

I hope this report will be useful to everyone who wants to make health care better and that it will inspire us all to redouble our efforts to meet the formidable challenges that lie ahead.

Niall Dickson

Chief Executive, The King's Fund

Key messages

- National leaders need to be honest about the scale of the financial challenges ahead.
- The Department of Health and strategic health authorities (SHAs) must resist reverting to 'command and control'.
- Primary care trusts (PCTs) need to take a leadership role for the whole of their local health care system in developing a response to the financial challenges ahead.
- Commissioners need to improve their understanding of the costs and benefits of local services if they are to reduce spending and drive improvements in productivity.
- Commissioners and providers need to recognise that reducing variations in cost and quality will be necessary but not sufficient to deliver the level of savings required.
- Commissioners and providers need to grasp opportunities to work with the independent and third sectors, where these can make a contribution to innovation and improvement.
- Commissioning at every level needs to be clarified and strengthened.
- Commissioners should look for opportunities to work more closely with local authorities and ensure that the interface between health care and social care does not become a battleground.
- Commissioners should realise the productivity and quality gains in care outside hospital by reviewing and rationalising the estate and harnessing technology.
- Commissioners and providers must actively engage the public and patients in the process of change.
- Providers need to find better ways to engage staff and to consider all options to improve workforce productivity.

Windmill 2009: 'the storm scenario'

Introduction

Much has happened over the past two years to put the NHS on a more stable financial footing, to put quality more firmly at the heart of the health care system and to strengthen the skills and capacity of commissioners. However, it is clear that the era of unprecedented investment in health care is over. The global financial crisis of 2008–9 will have a lasting impact on public finances, given the huge level of government borrowing. The main political parties agree that the next government will need to reduce spending and the NHS will not be immune from the pressures that will be felt throughout the public sector. These exceptionally challenging prospects for the NHS lie behind the decision to create a 2009 version of the Windmill simulation exercise – entitled 'the storm scenario'.

The financial context

While there are differing views about the potential impact of the recession on public expenditure, this report has been fortunate to be able to draw on the joint report between The King's Fund and the Institute for Fiscal Studies (IFS), *How Cold Will It Be?*, which sought to understand the implications of the economic downturn for health spending (Appleby *et al* 2009). It outlined three plausible scenarios for health care funding over the next six years, each involving differing assumptions about the likely increase or decrease in funding:

- 'tepid' (annual real increases of 2 per cent for the first three years and 3 per cent for the second three years)
- 'cold' (zero real change for six years)
- 'arctic' (annual real reductions of 2 per cent for the first three years and 1 per cent for the second three years).

The report also set these scenarios into a wider context that underlines the difficulties that lie ahead.

- Average annual real spending has increased by around 4 per cent over the lifetime of the NHS.
- There has never been a six-year period of zero real growth in the history of the NHS, and certainly no continuous six-year period of real reductions.

- A zero growth assumption for the NHS would imply an average annual real reduction of 3.4 per cent for all other public spending departments, including education and defence.
- Even the ‘tepid’ growth scenario is one percentage point less than the historic NHS average, and nearly one-third of the real average annual increase over the last decade.
- Demographic pressures alone suggest a need for a 1.1 per cent annual increase in NHS spending.
- The latest figures from the Office for National Statistics (ONS) show that between 1997 and 2007, measured UK NHS productivity *fell* by 4.3 per cent, and averaged –0.4 per cent each year for the whole period.

The Department of Health has indicated that £15–20 billion of efficiency savings will be required in the period 2011–14 – up to one-fifth of total NHS expenditure (Burnham 2009). The King’s Fund/IFS report estimated that compared to Sir Derek Wanless’s 2002 recommendations for future funding of the NHS – recommendations that underpinned the recent period of funding growth – the ‘gap’ between the Wanless requirements and the ‘cold’ and ‘arctic’ scenarios could range from £21 billion to £40 billion by 2016/17.

For a service that in recent years has become used to consistent financial growth, the scale of the financial challenge ahead is perhaps difficult to comprehend. Even if the Wanless recommendations were to be abandoned, it is clear that conventional cost improvements could not achieve the scale of year-on-year savings required. Managers of NHS organisations now have to plan for what, in effect, amounts to a 20–30 per cent reduction in NHS spending for the five-year period from 2011. Meeting this enormous challenge will require a radical transformation in the way services are delivered – and concerted action from policy-makers, clinicians and managers at every level.

The wider context

Windmill 2009: ‘the storm scenario’ is about more than just a predicted change in the level of health care funding. Sebastian Junger’s book, *The Perfect Storm* (1997), described a unique set of meteorological phenomena that combined to create a storm of gigantic proportions – the worst storm possible. Given the current policy trajectory and the financial outlook, it does seem possible that the circumstances facing health and social care could combine to produce a set of pressures whose impact could be as devastating as Junger’s nightmare.

Alongside changes in the level of funding, there are three major contributors to the power of the financial storm, each of which will result in a significant

growth in demand. First, the ageing population, technological advances, the government's determination to tackle health inequalities, and the impact of recession on people's physical and mental health will all require significant year-on-year increases in activity. Second, rising public and patient expectations about how and when they are cared for will put pressure on services to do more and to be more responsive. This trend is likely to be reinforced by the introduction of patients' rights in the NHS Constitution and ministerial statements about rights and entitlements (Department of Health 2009a). In social care there has been a push towards so-called 'personalisation', which aims to increase the power of the user and to underline the need for individually tailored support. There are already plans to extend this approach into health care – especially for people with long-term conditions. Third, in a service that employs more than 1.3 million people – representing at provider level some 70 per cent of total NHS spending – there is an annual increase in the wage bill estimated at 2–2.5 per cent real wage drift. This arises in part from Agenda for Change, which allows for salary increases to be allocated automatically with no tie-in between reward and productivity gains.

In short, there are a series of forces within and beyond the health care system over which funders and providers have limited or no control, but which are likely to have a profound impact on where services are delivered, how, and to whom, over the next few years.

The simulation questions

In the design stage of Windmill 2009, we consulted a wide range of individuals, from frontline managers and clinicians to policy-makers and economists, to establish the focus for the simulation. A number of questions emerged.

- Will the years of plenty be a sufficient cushion to enable the NHS to make the necessary adjustments without a detrimental effect on patients?
- How will the various groups and organisations involved in the planning and delivery of health care react to the financial challenge? Will they make decisions that help their own organisations or act in a way that promotes the sustainability of the whole health and social care system?
- What will happen at the interface between health care and social care? Will the resource pressures on both sides hamper integrated care?
- Can the system deliver both better quality and improved productivity? What new incentives are needed to support productivity improvements? Will patient care – in particular, access and waiting times – suffer?
- What do the changes mean for public and patient engagement?

- How will the system respond to increasing incidence of mental and physical ill health associated with the effects of unemployment and financial uncertainty?

These questions informed the design of the simulation.

Windmill 2009: the process

The Windmill 2009 process comprised three main stages:

- a design workshop in July 2009, which brought together a number of leading thinkers and commentators from across the system, to help identify the main drivers and refine the issues to be explored in the simulation event
- the storm scenario simulation event, held over two days in late July 2009. This brought together around 60 people – policy-makers, regulators, commissioners, and providers (NHS and independent sector) as well as managers, clinicians and representatives of patients and the public. In addition to their contributions during the event, we also received helpful comments and reflections from participants, giving their interpretation of what happened during the simulation
- a moderating workshop held in September 2009 to review, test and refine the emerging findings and messages.

Appendix A lists those who participated in one or more of these events.

While the simulation event remains at the heart of the Windmill process, it is important to emphasise that what happened during the ‘play’ – although generally considered highly realistic – was a means to generate learning, and not an end in itself. Each stage in the process was important in contributing to the insights and recommendations set out in this report.

For the simulation itself, we needed to model a whole system, but we also had to make the task manageable. This meant we had to be selective about how much of the system we could bring into play. We decided to include both social care and mental health for adults, but to exclude services and support for children and young people and for people with learning disabilities. This should not be interpreted in any way as a reflection of their importance; it was simply felt that the dynamics of commissioning and providing these services would require a different mix of players and would be difficult to simulate alongside other services. We recognise that the impact on these services is likely to be different but just as powerful. Using a simulation to explore the effect and response in these areas would be an interesting exercise in its own right.

About open simulations

The orthodox approach for planners is to employ ‘hard’ approaches to predict the future. Historical, quantitative data are used with varying degrees of

sophistication to extrapolate from the current position (a notional 'Point A') to some future 'Point B' on the horizon. This approach may work for relatively simple issues in relatively stable circumstances. But it offers much less predictive value when we are trying to understand the future of complex social systems operating in more chaotic environments.

In these circumstances, there are usually so many forces and drivers at work and so many powerful stakeholders involved that the sum of all their interactions is impossible to model quantitatively. We have therefore found that a more useful approach is to use 'soft' or qualitative futures. These draw directly on the experience and judgement of people who are involved in the system we want to understand. One of the most powerful soft futures processes is the behavioural or 'open' simulation.

Open simulations are based on the premise that what happens in complex social systems is the product of formal and informal negotiation and bargaining between large numbers of stakeholders that represent national, professional, institutional and personal interests. To replicate this large-scale negotiating process, two key ingredients are needed – a group of participants who are representative of those in the real world, and a fictional but realistic operating environment for them to work in.

As in real life, open simulations allow any conventions, structures and policies to be challenged and renegotiated, and the only rules that apply are the ones that already govern the players in their everyday work, such as legal obligations or regulations around organisational or professional conduct. Participants are not asked to 'role play'; instead, they take a position in the simulation that mirrors their job in the real world. This means that their behaviour in the simulation is accurately informed by their real-life insights and experience.

Open simulations are like a giant version of the flight simulators used to train pilots. They offer a highly realistic but safe learning environment for the 'crew' – in our case, some 60 players. They provide one of the most robust ways of helping us to understand how complex social systems respond to large-scale and rapid change. As such, an open simulation was the perfect tool for helping us to understand how the NHS might respond to 'the storm scenario'. As one of the Windmill 2009 participants put it when experiencing a rather tense moment in the simulation, 'Believe me, this is too real!'

The design of 'the storm scenario'

The Windmill 2009 simulation explored two periods of time. Round one covered the period from October 2009 to April 2010 (the end of the financial year); round two covered the period from January to December 2011. The reason for this

timing was to explore how participants would plan for the anticipated changes with the storm on the horizon, but with little scope to alter or challenge current policies and structures. The second round, set nine months after a general election and with a new government in place, aimed to explore what would happen if players could change almost everything. The only constraints set were to stay true to the founding values of the NHS – free at the point of delivery, tax-based, and with universal access. This was considered to be realistic no matter how bad the downturn, and no matter which party was in government.

However, we did not wish to predict which party would be in power after the election, not least because we wanted to avoid the players ‘projecting’ policies currently being put forward by political parties onto the game. For this reason, the simulation assumed a narrow electoral victory with one party having a slim overall majority.

As the full impact of the recession emerged, the government established an ‘emergency strategy committee’ (ESC) for health and social care, led by the Secretary of State. The ESC’s brief was to use all the experience and judgement available to develop a political consensus about the best way to maintain or improve quality and access to services, and to deliver real reductions in expenditure in the short to medium term.

In addition, the new government gave our imaginary health economy a special ‘crucible’ status, which gave the players extensive freedoms, including freedom to innovate, freedom from central control and freedom to develop cross-government solutions. Again, this was to ensure that participants were not hindered in the scope or nature of their solutions by the current administrative circumstances. In order to provoke more radical thought, participants were provided with examples of possible national or local policy changes in the form of a ‘leaked Department of Health memo’ about what policies might be introduced to cope with ‘the storm scenario’. The ideas contained in the ‘leak’ (*see* Appendix B) were drawn from the ideas generated in the earlier design workshop.

Part of the reason for introducing the special freedoms into the imaginary health economy was to load the game in such a way that the health and social care system was able to survive the storm – there would be no practical learning if everyone had drowned! Also, by giving participants freedom to set their own policy framework, it was possible to assess whether the current range of policies were likely to help or hinder the ability of the health and social care system to cope.

The 'exam question'

It was important that everyone involved understood the nature and scale of the challenge facing the system over the next few years. To make this as clear as possible, we borrowed an 'exam question' from some earlier work undertaken by Loop2 in Cambridgeshire about how to make each NHS pound work harder. For simplicity we represented this in the form of an 'equation':

$$\underline{X = (Y - 15\%) + Q + A + (I - Z)}$$

3r

Here, 'X' is the future funding allocated to the health system, 'Y' is the current level of funding, 'Q' and 'A' represent improvements in quality and access to care, and 'I-Z' refers to a reduction in health inequalities. The '3' represents the three financial years over which we felt that the reductions would have to be made, while the 'r' signifies the need to make these savings and quality improvements on a recurrent basis. In other words, participants were asked to operate in a system that would face 15 per cent funding cuts over three years, having to achieve access and quality improvements and a significant reduction in health inequalities, with the expectation that after three years, they would be faced with the same challenge again.

What happened in Windmill 2009

The following organisations were represented in the simulation, planning and providing services to the county of ‘Heartshire’.

- **The Department of Health** – the Department was working closely with the strategic health authorities (SHAs). They were considering two dilemmas: the balance between collaboration and competition, and how to maintain system stability in the run-up to the election.
- **Monitor** – the foundation trust regulator continued with its exacting performance requirements, but was considering what actions it should take in situations of quality failings.
- **The Care Quality Commission** had a specific brief to look at the effects of the economic downturn on the quality of care and on the interface between health and social care.
- **Central Strategic Health Authority** – with most trusts having achieved foundation status, the SHA was effectively ‘blind’ to the provider side. Its aim was to establish a more ‘coaching and enabling’ approach with primary care trusts (PCTs). The challenge was whether this style could be sustained as the financial position worsened.
- **Heartshire PCT** – a large and relatively high-performing PCT. It owned a network of community hospitals in various stages of use and repair.
- **Harlequins Primary Care Organisation** – an ambitious practice-based commissioning (PBC) group keen to push the boundaries of responsibility for commissioning.
- **Heartshire Community Health Services** – the PCT’s arm’s-length provider. Decisions about the future governance and structure of this entity had been put on hold awaiting improvements in performance.
- **Brownville University Hospital NHS Foundation Trust** – a large teaching hospital shouldering considerable debt from the recent completion of a private finance initiative (PFI) contract.
- **Reidhill Hospitals NHS Trust** – a high-performing trust with two sites and ambitions to decentralise its services.
- **Umbur Mental Health Foundation Trust** – this trust provided the full spectrum of mental health care but there were gaps in certain services, which it attributed to a low per capita spend on mental health.

- **Blueper Independent Healthcare** – part of a national independent health care chain. Blueper had recently diversified into wellness services and had taken over a leading provider of mobile diagnostic and theatre services. Blueper had well-developed partnerships with other commercial providers of telecare and informatics.
- **Vermillion Primary Care** – an independent primary care development company that worked with GPs, dentists and pharmacists to develop new facilities and run primary care services.
- **Magnolia Care** – an independent sector organisation that provided tailored social care to people in their own homes. The services included basic care, shopping and meals. It provided around one-third of the social care in the county.
- **The Heartshire Local Involvement Network (LINK)** – this was one of the first LINKs to become established, with strong support from Azure People First – the host organisation.
- **Heartshire County Council** – a progressive council that was ‘improving well’; it was represented in the simulation both by the health overview and scrutiny committee and adult social services.
- **The Heartshire Gazette** – a local paper with a longstanding interest in local health stories.

Participants were provided with a detailed briefing about the health and social care commissioning and provider arrangements within Heartshire, including the key financial and performance challenges.

Round one: October 2009–April 2010

All commissioning and provider organisations were asked to put together revised plans for coping with ‘the storm scenario’. Heartshire PCT, as system leader, had been asked by the SHA to co-ordinate a plan that stipulated:

- actions that would **reduce spend for commissioners and costs for providers** (for example, reducing excess bed days, and follow-up rates)
- actions that would **reduce spend for commissioners without reducing costs** (for example, where national tariff means commissioners currently pay twice for parts of a pathway). This would involve ‘unbundling’ of certain tariffs
- actions that would **reduce costs for providers without changing commissioner spend** (for example, moving from inpatient to day case surgery). The PCT would have a keen interest in the effects of these actions on patients.

Given that the first simulation round focused on the present, the requirements of the current national operating framework (2009/10) were assumed to apply. The preferred approach to efficiency improvement was through innovation and quality improvement, based on the principles of co-production, subsidiarity, clinical ownership and leadership. Organisations were asked to ensure that long-term improvements in health were not sacrificed for short-term financial expediency.

Further challenges facing the Heartshire system included:

- ongoing issues with health inequalities
- rising demands for health and social care from the county's growing elderly population
- variable quality in primary care and in PBC
- a large-scale PFI development casting a shadow over foundation trust financial performance
- a local involvement network campaigning for improvements in quality and access to care
- requests for regulators to consider reducing the costs of regulation.

In the remainder of this section, we outline the key developments that took place in the first simulation round.

Centre-local relations

- With the general election just months away, the Department of Health's main concern was to minimise political controversy and debate about the impact of future funding changes on the NHS and on patients. Having embedded a policy of encouraging greater local leadership of the NHS, the Department was wary of taking a very centralist line – for example, by specifying how 'storm scenario' plans should be developed and what they should contain. But, kept well informed by the SHA and regulators about how local health and social care systems were reacting, the 'centre' had little hesitation in attempting to block controversial or politically sensitive proposals.
- An interesting tension arose between the Department of Health and Monitor around the issue of productivity. As noted earlier, the NHS's recent track record of productivity improvements has been relatively poor. The regulator felt that productivity was an important focus for foundation trusts and a helpful indicator of their performance. But a proposal to highlight variations and trends in productivity was blocked by the Department on the grounds

that this was not good for staff morale and public confidence; rather, the focus should be on quality of care.

- The Central Strategic Health Authority had been moving away from a traditional performance management relationship with its PCTs, towards a more coaching and facilitating relationship. However, as the financial situation started to worsen, its commitment to this new approach proved to be short-lived, and it reverted to its previous focus on performance management, challenging the PCT and its plans. The SHA felt caught between the Department of Health and its political concerns on the one hand, and the practicalities facing PCTs in finding appropriate solutions to the downturn on the other.
- Frustrated at the lack of detail in the PCT's plans and the speed with which these were developed, the SHA realised that the PCT had very different ideas about the style and content of the financial strategies and plans required. In response, the SHA tried to impose both an overall approach and specific solutions on the Heartshire health system.
- As one PCT participant put it, 'There seemed to be a clear desire to demonstrate that the PCT as a commissioner had failed, which would "prove" that the other parties should be given the job. Pre-eminent was the SHA.' The PCT felt frustrated by the Department of Health and the SHA's blanket claims about the scope for productivity improvements in different sectors. The commissioners felt that the Department and the SHA lacked real evidence about what was possible in local health systems, and were mistrustful of the PCT's claims about their patch.

The commissioners

- Heartshire PCT took its role as system leader seriously and invested considerable time in engaging the different stakeholders, aiming to establish a consensus about high-level strategic principles. It identified around 20 different interest groups whose views it needed to manage. While some of the challenges involved may have been an artifice of the simulation timescale and participants, the importance of effectively managing relationships became clear.
- The PCT was aware that it had just one planning round in which to prepare the health and social care system. It identified some key factors that could inhibit its ability to draw up and implement a credible plan. The overview and scrutiny process and the power that local politicians had to challenge PCT and provider proposals was one of the most significant 'show-stoppers'. A further constraint was the extent to which tariffs were fixed or could be

used as a ceiling below which there was scope to negotiate with providers on prices. However, the SHA and the Department of Health refused to support the latter unless it was linked to shifts from acute to community-based provision.

- Other key elements of the PCT's strategy included establishing a pooled fund for continuing care with the local authority, as well as joint commissioning and encouraging collaborative solutions from providers. While PCTs have used similar approaches in the past, there was little evidence of reflection by Heartshire PCT on the risks of using these levers or how robust they might be in delivering the necessary savings.
- Struggling with its complex relationship management task, the PCT became unresponsive to opportunistic requests from independent sector providers, who were offering proposals that could help reduce the costs of commissioning and also improve quality for patients. By the end of the planning period, the PCT felt that it had an overarching strategy to help manage the storm scenario. However, it was clear that this fell short of the SHA's expectations and did not appear to give providers sufficient clarity about its commissioning intentions to inform their own business plans.
- On a more positive note, the PCT supported a 'managed care' bid from the Harlequins Primary Care Organisation (PCO), which had a strong referral management approach at its centre. There was recognition that the clinicians brought a helpful understanding of the interface between physical and mental ill health and ambitions to expand community-based services. However, they offered far less reassurance about the financial and governance arrangements. The PCO had asked the PCT for an allocation of 95 per cent of the current commissioning spend for their population. A risk-sharing arrangement would allow both parties to benefit from the savings made. The perennial conflict between the PCO's commissioning and providing aspirations was not addressed by either the PCT or the PCO.
- The PCT was concerned about whether this managed care model could work in its other localities once Harlequins PCO had demonstrated proof of concept. Elsewhere in Heartshire, PBC remained weak and one option for the PCO might have been to offer to extend their commissioning remit by taking on this responsibility for a wider population. However, Harlequins PCO rejected this option – it maintained the view that effective commissioning meant working with like-minded practices where it was easiest to establish consensus.

NHS providers

- Heartshire Community Healthcare recognised that it needed a bold change in the way it worked and the way that the chain of community hospitals was used. Without a clear commissioning framework from either the PCT or the local authority, it found the planning process a real challenge. One participant commented, 'We wanted a very simple framework that would give us some assurance about income expectations.'
- Heartshire PCT entered into discussions with all providers about how it would use QIPP – quality, innovation, productivity and prevention – to incentivise change. However, the quality aspect was rapidly overlooked, with the discussions focusing on productivity alone.
- The two acute providers found that the financial implications of the PFI development and other 'stranded costs' left them with little room for manoeuvre. While there was scope for estate and service rationalisation, they felt this debate needed to be conducted more widely. Neither provider felt they had the legitimacy to co-ordinate a strategic review across the whole county, but they recognised the need for such a review.
- Having struggled with options around service networks, the providers opted for what they felt was a natural solution – to merge. This option received little support from regulators and from the PCT, who took the view that structural changes would distract attention from the real task in hand and could present real risks, not only to realising efficiency and quality improvements but also potentially to meeting the Care Quality Commission's registration standards.
- The importance of a strategic approach to estate rationalisation emerged in parallel discussions between the Umber Mental Health Trust and Heartshire Community Healthcare. Agreeing to share space in community clinics and hospitals was a relatively straightforward move and was supported by the local involvement network. The challenge, however, was how to share the financial savings and benefits, and any risks.
- Umber Mental Health Trust recognised that with payroll as one of its largest costs, it needed to look at the workforce profile to reduce overheads. Use of agency staff and NHS Professionals was an easy target, and more imaginative flexible staffing arrangements were pushed through.
- Stereotypical assumptions about mental health trusts on the part of commissioners and acute providers hampered informed negotiations with Umber Mental Health Trust. The provider felt that its broad experience of handling public–private partnerships and risk, managing the shifts from a central to a more dispersed model of care, and engaging service users in

change was dismissed, and opportunities to extend this learning to other parts of the NHS were ignored.

- The trust was also surprised that the main discussions about productivity gains were with community health care and acute providers. It noted that mental health should also be expected to contribute to improved productivity, but that commissioners may need to focus those savings on tackling the worsening levels of mental health associated with the impact of recession and unemployment.

Public and patients

- Commissioners, NHS and independent sector providers alike recognised the importance of engaging with the local involvement network in discussing their plans. But the level of engagement was patchy. Public representatives felt that they had not been fully informed about the scale of the financial difficulties, and that the discussions had focused more on new forms of services than any reductions that might have to be made. Most of the dialogue had been platitudinous and opaque. So when discussions about the potential closure of a hospital finally took place, public representatives felt unprepared; they were left with little choice but to focus on their own agenda of improving access and quality.

Local authorities

- Heartshire PCT started the round with a productive relationship with Heartshire County Council's Adult Social Care Directorate, and appeared keen to learn from the local authority's experience of market management. But social care commissioners felt that their harder approach to procuring services was not well received by their NHS colleagues. The local authority was also keen to press ahead with the personalisation of social care and this did not sit comfortably with the approach the PCT was taking to commissioning. For its part, Heartshire PCT expressed scepticism about the timescales required for formal procurement exercises, preferring to work with incumbent providers as partners than going down the less familiar route of tendering services.
- Having identified the need for local political support for its plans, the PCT overlooked its relationship with the overview and scrutiny committee. The politicians felt that there was little transparency in the PCT's plans, which made the committee mistrustful of the proposals. Coupled with its own financial challenges, the committee's mistrust of its partner led to the council withdrawing from discussions about integrating commissioning.

The independent sector

- The contrast between the PCT's relationship with the PCO and with the other independent sector organisations could not have been starker. Whereas the PCO was seen as the PCT's partner and ally, the independent sector organisations felt they were, for the most part, treated with indifference, if not disdain.
- Magnolia Care – an established provider of home care – felt particularly rebuffed by the PCT, having offered a practical approach to preventive care and early discharge from hospital at a lower price than NHS equivalents. It also demonstrated willingness to change its model of social care provision by offering a greater range and choice of support, and by entering into negotiations with the council's Adult Social Care Directorate on an 'open book' basis in return for a larger share of the market. On reflection, Magnolia felt that while it had tried to show that it understood the commissioner's problems by demonstrating its strong business acumen, it had inadvertently scared off a potential purchaser.
- Independent sector providers received a more positive response from NHS providers, who could see the benefits of partnerships and alliances. One common sticking point, however, was whose brand would predominate. NHS providers were nervous of trade union opposition to anything that might be perceived as privatisation.
- Blueper Independent Healthcare offered some innovative informatics and telecare products, but experienced similar treatment to Magnolia. The PCT was concerned about patient perceptions of technology solutions even though they offered scope for quality and efficiency gains. It was also nervous about investing in new approaches in case they failed to deliver the promised savings.
- While risk-sharing arrangements were discussed with providers, the commissioner's lack of knowledge or experience of how this should be done put a dampener on any further negotiations. While not explicitly discussed with Blueper, the PCT later acknowledged that another reason why they rejected this option was the effect that home care solutions would have had on acute providers. Local NHS providers were already in financial difficulty, and the PCT feared that further shifts in activity could make things worse.

The regulators

- As the financial outlook compounded the more immediate financial challenges, Monitor found that the foundation trusts were quite open about their difficulties. However, the regulator was ultimately frustrated that there

was far more focus on problems than on solutions. It sensed that trusts were looking for special treatment or a change in national requirements rather than taking the hard business decisions needed to fulfil their performance obligations.

- The Care Quality Commission was sympathetic to the predicament faced by commissioners and providers, but held firm to its duty to provide better information to service users about variations in the quality of care. It also announced a periodic review of the impact of medium-term financial planning on the quality of care for patients.

At the end of round one, the Heartshire health and social care system recognised that it had struggled to agree a robust plan about how it would weather ‘the storm scenario’. Despite the briefing about the future financial position, there was a lack of urgency in the discussions that was not helped by the Department of Health’s preoccupation with the implications of the impending election. With just one planning round between the present and the likely date when real cuts in public expenditure might be imposed, this was a wasted opportunity to get the system ready.

Round two: January-December 2011

Round two started with a presentation from the ‘Secretary of State’. Reflecting on the performance of the Heartshire health and social care system in the previous round, he acknowledged that while local organisations had not used the planning period to best effect, this was not a time for politicians to try to manage the NHS centrally. The ‘emergency strategy committee’ was looking for bold ideas from the Heartshire economy as one of its ‘crucible’ zones. Access to central capital had been largely shut down, leaving PCTs and foundation trusts to find their own solutions.

Early talks in this round included some innovative ideas to help balance the equation between rising demands and lower levels of funding. Ideas included:

- charges for first GP appointments
- online GPs
- national campaigns and incentives to encourage greater self-care and responsibility by patients
- salary freezes for senior managers and clinicians
- national contracts for consultants to facilitate clinical networks across organisations
- lead providers negotiating their own supply chains

- getting rid of national tariffs
- replacing PBC with different forms of clinical leadership and advice to commissioners
- franchising urgent care provision to providers with incentives to provide care at the most appropriate point relating to patient needs.

An aggressive programme of market testing for all services was also mentioned. Even the abolition of SHAs was considered, with their roles absorbed by Monitor and the Care Quality Commission.

Centre-local relations

- Early decisions taken by the centre included a reduction of tariff prices by 2.5 per cent and a pay freeze for senior managers and clinicians. Both decisions were broadly supported by the Heartshire health system, although the PCT argued for greater freedoms, with the national tariff a maximum that would guide local price negotiations. Part of the savings from the reduction in tariffs was earmarked for stimulating innovation, although the mechanisms for accessing this fund were unclear. Employers welcomed the pay freeze, as it limited local wrangling with staff side organisations. However, it was acknowledged that a pay freeze would simply limit cost increases in the short term – it would not release cash, and could not be a permanent solution.
- A gesture from the centre – a reduction in the headcount at the Department of Health and the SHA – went almost unnoticed by local organisations.
- Other than these policy decisions, the Department of Health was somewhat preoccupied with negotiating roles and relationships with Monitor and the Care Quality Commission.

The commissioners

- At the end of round two, Heartshire PCT felt that the new freedoms it had sought had given it greater flexibility to adjust to ‘the storm scenario’. It ditched the old regime of central targets, replacing them with a balanced set of performance measures focused on individual services rather than organisations. It felt that these enabled it to focus on the essential priorities for the county. Overall, the PCT felt that it had concentrated too much on looking for the ‘magic bullet’ that would solve the financial difficulties rather than opting for an approach that would have secured savings through a variety of means.
- The PCT sought to reduce commissioning overheads by integrating some commissioning functions with the local authority and reducing its headcount

- to reflect the functions that had been delegated to the Harlequins PCO. The professional executive committee was also disbanded and replaced by more episodic and targeted arrangements for using clinical leaders in the system.
- While accepting that competition has a role to play in reducing costs, Heartshire PCT remained nervous about expanding competition within the market, arguing that this would lead to more spare capacity and inefficiency. The consequence may have been reduced patient choice, but this was felt to be a better alternative to the loss of public confidence that would come from more drastic cuts in services.
 - Two options for balancing income and expenditure were not explored: prioritisation of services and needs, and commissioners focusing on variations in provider performance. With regard to the first, providers were looking for the PCT, as system leader, to ‘rule things out’, but this did not happen explicitly. With regard to the second, it may be that this approach – a core lever for commissioners in contract management – was taken as given. However, an alternative interpretation was that the potential productivity gains from better performance management were underestimated.
 - Undeterred by their experiences with the local authority in the first round, Heartshire PCT and the county council moved to establish Quality and Innovation in Commissioning (QUIC) – a joint commissioning body with clinical and public membership, accountable to both the authority and the PCT.
 - The PCT felt it had established an understanding with the council officers that there was potential to merge local authority and NHS commissioning once proof of concept had been established – that is, structure would follow function. While the name may have been different, it was difficult to see how these new arrangements would have aided decision-making; in fact, with two sets of reporting arrangements, they may well have slowed things down. Nor was it clear what the remaining role of the PCT would be. QUIC’s remit was ambitious – it would be charged with agreeing thresholds for eligibility for treatment, services that would not be commissioned, the introduction of risk sharing in all contracts, and the use of prior authorisation processes for certain high-cost, high-risk treatments.
 - One significant freedom that the PCT identified was the abolition of tariffs for emergency care and for services for people with long-term conditions. Tariffs were, however, felt to be a useful ceiling for elective care. Emergency care would be franchised with a contract incentivising one or more providers to treat patients at the most appropriate and efficient point of access.

- By the end of the second round, Heartshire PCT was disappointed that its efforts to secure a collaborative and ‘whole system’ approach had not gained greater support. It concluded that it needed to be far better at communicating the principles it thought had been agreed. It also felt it needed to ensure that there were clear, measurable indicators of system performance, and to gain public and clinical support for treatments that should no longer be provided (such as those that were ineffective or reflected lifestyle choices). Specifying referral thresholds was a further area where commissioners felt they could gain some influence over health care spending.

NHS providers

- Round two saw a rapid development in terms of active collaboration and planning between the acute, community and mental health providers in Heartshire. With the opportunity to put sovereignty of the legal entity to one side, providers felt they had greater capacity to secure clinical networks and service reconfiguration than under Monitor’s current strict focus on organisational requirements. Organisational mergers, discussed in round one, were quickly dismissed as being too distracting.
- Buoyed by productive discussions and active clinical engagement in developing their plans, some participants even questioned the need for a commissioner if funds could be allocated to the network directly.
- The outcome of these discussions was a radical savings plan that would be delivered over a three-year period. The actions in this plan included tendering for a single provider of intermediate care, focusing specialist services in two locations and using existing NHS and local authority estate to deliver locality services in a number of joint service centres across the county. Coupled with investment in technology to support an increase in home care, this freed up estate that could be either leased or disposed of.
- While significant collaboration with other NHS providers was evident, this took place in parallel to the planning work undertaken by commissioners. The PCT’s attempt at whole system consensus through a high-level framework, while interesting, was rapidly put to one side by the providers’ focus on practical deliverables in the short and longer term. Primary care professionals were insufficiently engaged in this endeavour, missing an opportunity to secure agreements about effective demand management.
- Both acute trusts found themselves managing the fallout of central announcements and frustrated at whether they would really have freedom to manage their own affairs. In an effort to placate staff, PCTs and providers

made reassuring and robust statements about protecting the workforce, as the NHS's most important asset.

- With hindsight, this lack of transparency about the scale of the challenges was as unhelpful to staff as it was to the public. The messages soon started to harden, with references to workforce downsizing through 'natural wastage'. When other approaches to cost adjustment failed to materialise, providers and commissioners recognised they needed a more constructive relationship with the trade unions if they were to deliver shifts in the workforce profile that could improve efficiency and maintain, if not improve, quality.
- It became clear that workforce disputes would be played out nationally, regionally and locally unless there was active engagement of staff side representatives across all professional groups at each of these levels. 'the storm scenario' could not be faced without active consideration of the workforce contribution.
- Brownville University Hospital Trust considered renegotiating the deal with its PFI partner, using opportunities presented by the current financial context (for example, lower interest rates) to argue for an early release or reduced premiums. In the long term, an early settlement of the debt might have proved both a cost-effective option and one that would give the trust the flexibility it needed to make changes in its estate and profile of services. Finding backers to provide the capital to do this was a challenge, however, so the trust continued to press Monitor and the Department of Health to consider using the innovation fund for this purpose. One suggestion was that the Department should buy out all remaining PFI contracts ahead of schedule. But with government borrowing already at an all-time high, it was far from clear where the money for this would come from, even if the idea had some merits.

The independent sector

- In round two, there were signs of a more mature partnership between Magnolia Care and Heartshire Community Health, but this was short-lived. In the end, Magnolia decided that it did not want to be a player in the NHS market. It had offered its management systems, including flexible staff rostering, and the community health services were interested in the efficiency gains that could be derived from these new patterns of working. Changes to staff terms and conditions, however, proved a real sticking point to further negotiations.
- Being able to employ staff directly on its own terms and conditions was crucial to Magnolia's business model. It felt that secondments would simply

not work, as the differences in reward packages between the staff groups would prevent savings being realised and would lead to tensions. The only option would be a separate management vehicle or a takeover by Magnolia. A variety of structural solutions were explored but, in the end, a full agreement proved elusive. Magnolia's tough stance on sickness absence, for instance, meant that it had absence rates of well below 2 per cent. If Heartshire's NHS employers were able to achieve these levels, there would have been significant gains in productivity.

- Vermillion Primary Care presented a range of ideas to the Harlequins PCO – risk stratification and utilisation management software, and performance management systems and processes that offered a more effective approach than traditional practice management models. Harlequins realised that these approaches would be needed if it were to realise its ambitious plans within its allocated budget. It also recognised that delivering these changes in working practice would require a significant cultural shift across all of its practices. Not surprisingly, Harlequins became even more bullish about which practices could be part of the PCO, and strongly resisted pressure from the PCT and SHA to expand its coverage.

Public and patients

- The local involvement network became more frustrated at the apparent lack of transparency and action in its local health and social care system. It noted that in the private sector, popular brand names such as Honda took decisive action to manage the downturn, and wondered why the NHS had delayed taking decisions. The irony that PCTs and trusts might be fearful of potential public opposition to changes appeared to have eluded the network.
- At the end of round two, patient representatives reflected that the patient experience was far from integral to the planning process. Patients appeared to be treated as if they were incidental to the service rather than valued customers. They challenged the assumption that patient choice was unaffordable under 'the storm scenario'. Social care participants noted that early experience with personalised budgets and self-directed support showed that giving people greater choice and influence over their care could also provide a system that was better value for money.

Conclusions

Despite the bold and radical ideas for new freedoms and flexibilities set out at the start of the year, by the end of round two, the cultural conservatism characteristic of much of the NHS had prevailed and many of the ideas failed to materialise. Nevertheless, the Heartshire health and social care system was far more focused

on ‘the storm scenario’ implications than it was in round one. It made use of the ‘crisis’ to push ahead with service reconfiguration that might have proved more difficult to achieve under conventional arrangements.

Three factors stood out as key enablers of change. First, collaboration between providers helped to establish a whole system solution. Second, cross-organisational clinical engagement aided this collaboration. Third, there was a new performance management regime for organisations and for service contracts that enabled institutional interests to be put aside, and enabled commissioners to introduce a balanced approach to performance monitoring with a stronger focus on patient care and the patient experience.

Round two also revealed some blockages and barriers to change. A lack of honesty and transparency with the public and staff representatives hindered productive relations. A lack of information about which services care commissioners had bought and what those services had achieved for patients made discussions about which services to cut very difficult.

Finally, lack of constructive relationships with independent sector organisations meant that opportunities that might have delivered better value for money and improved quality of care were not pursued. Whole system collaboration is an important catalyst to help align the various approaches to responding to the storm. But collaboration should be guided by its merits, rather than past alliances – there are circumstances where new providers can bring innovation, quality and productivity improvements. Commissioners need to balance the desire for system stability on the one hand, with the benefits to be gained from disruptive innovation on the other.

Key themes and lessons for policy-makers, commissioners and providers

This section draws out the main learning points from the Windmill 2009 process. The moderating workshop held after the simulation event augmented what happened in the simulation itself. It also made it possible to develop a more pragmatic analysis of what will be required if health and social care systems are to respond effectively to the major challenges that lie ahead. Eleven key themes emerged, summarised in the box below. For each theme, we describe the issues involved, and set out what needs to be done. The main recommendations from the Windmill process are presented in the final section.

- National leaders need to be honest about the scale of the financial challenges ahead.
- The Department of Health and strategic health authorities (SHAs) must resist reverting to 'command and control'.
- Primary care trusts (PCTs) need to take a leadership role for the whole of their local health care system in developing a response to the financial challenges ahead.
- Commissioners need to improve their understanding of the costs and benefits of local services if they are to reduce spending and drive improvements in productivity.
- Commissioners and providers need to recognise that reducing variations in cost and quality will be necessary but not sufficient to deliver the level of savings required.
- Commissioners and providers need to grasp opportunities to work with the independent sector and third sector where these can make a contribution to innovation and improvement.
- Commissioning at every level needs to be clarified and strengthened.
- Commissioners should look for opportunities to work more closely with local authorities and ensure that the interface between health care and social care does not become a battleground.

- Commissioners should realise the productivity and quality gains in care outside hospital by reviewing and rationalising the estate and harnessing technology.
- Commissioners and providers must actively engage the public and patients in the process of change.
- Providers need to find better ways to engage staff, and to consider all options to improve workforce productivity.

Being honest about the scale of the challenge

The issues

During the planning of the simulation, it appeared that politicians were very reluctant to be transparent about the detailed prospects for public expenditure funding and what it would mean for the NHS. However, partly in response to pressure from The King's Fund and others, there has been a significant shift in this regard, and there now seems to be a greater willingness to be more open about the difficulties that lie ahead, for the health service and the public sector as a whole. This openness needs to continue, with an acknowledgement that difficult decisions need to be made – in particular, it would be a mistake to believe that there will be no reductions in frontline staffing or that the current pattern of institutions can or should be sustained. The lack of clarity about the likely scale of the funding squeeze during the simulation meant that local organisations were uncertain of the assumptions they should make about the future and therefore felt unable to draw up firm plans.

In a speech at The King's Fund in late September 2009, Andy Burnham, the Secretary of State for Health, suggested that it would be wrong for individual NHS organisations to imagine their own futures before the government had set out its spending plans (Burnham 2009). That may be true in terms of detailed numbers, but diligent PCTs and other health organisations should be preparing for the storm ahead. There is a valuable window of opportunity to plan sensibly and strategically now, rather than later, when there may be little alternative but to 'slash and burn'.

The mantra of the moment in the NHS is 'QIPP' – quality, innovation, productivity and prevention. While this initiative represents a laudable ambition, and there is evidence that raising quality can reduce costs, there is a danger that it will encourage a 'softer' debate about quality improvement and innovation, and that the 'hard' part of productivity – which is directly linked to reducing costs – will become secondary or sidelined. On the other hand, if the NHS only focuses on productivity and funding, there is a danger that the focus on quality

and patient-centred services will be lost. The lessons from Mid Staffordshire NHS Foundation Trust's significant failings in quality of care should not be forgotten.

Based on all the contributions to Windmill 2009 and what we know from previous economic downturns both in this country and abroad, it seems unlikely that the measures necessary to meet the financial challenges can all be achieved simply by raising quality; indeed, the real risk is that financial pressures will lead to reductions rather than improvements in quality. It is vitally important for the system to exploit the link between productivity and quality improvements, but the tenor of the current debate, focusing on service improvement, slashing 'bureaucracy' and protecting jobs, will create false expectations among staff and the public and underplay the scale of the savings required.

What needs to be done?

- Politicians' reluctance to spell out what the financial challenges mean for the health system is understandable. However, as more information becomes available in the run-up to the election, they must be prepared to be more explicit. This will apply both to the government's pre-budget report and other statements, and the opposition parties' emerging views, as well as commitments made in the various election manifestos.
- The new government, whatever its political persuasion, will have to resist any temptation to 'muddle through'. The system needs an early, explicit indication of funding prospects, and a realistic analysis of the limitations of conventional cost improvement measures. It is vital that ministers help to create a climate that will enable local leaders to engage meaningfully with the public and with health staff over the more radical measures that are likely to be necessary. The centre should not shy away from the fact that these are likely to mean fewer hospitals and a different range of out-of-hospital providers, and fewer staff.
- PCTs and providers should not wait until after the election to prepare for the storm. They need to start engaging their staff and other local organisations and interested parties now, to prepare realistic plans and encourage a mood of resolution rather than resistance. Clinicians throughout the system need to be at the centre of these preparations. In the absence of firm and detailed forward funding commitments – which might not be available until after the election – local organisations may need to use pessimistic assumptions in their planning, on the basis that it is always easier to accelerate spending than to rein it back.
- The boards responsible for individual organisations need to have a clear understanding of the extent of the financial challenge and clear plans for

how they will manage and adapt service provision as well as staff and public expectations. No decisions should be taken – especially those relating to capital investment or service change – without first considering their affordability under more testing financial assumptions, and their potential to limit the organisation’s room for manoeuvre in the future.

- QIPP has proved invaluable in galvanising the health service into understanding that ‘more of the same’ will not do; there is a need for innovation and radical change. It has also had the desired effect of signalling to commissioners and providers alike that cutting costs by reducing quality will not be acceptable. But the Department of Health and SHAs need to be aware that though QIPP may have highlighted these issues, there is still a need to make real savings.

No return to ‘command and control’

The issues

Throughout the simulation event, the presence of the SHA and the Department of Health, closely watching local negotiations, created an uneasy tension. This may have been an artifice of the simulation in that the intermediate tier was literally much closer to the action than would be the case in reality. However, as the financial pressures started to take hold, the restraint evident at the outset was abandoned, and both the PCT and the providers felt the hand of the centre intervening in the local system.

Given the scale of the challenges ahead, there is a real risk that the centre will return to what some regard as its default approach of ‘command and control’, ignoring the lessons of the past, which have demonstrated that it is impossible to effectively manage a system as complex as the NHS from the centre. To attempt to do so would also undermine the hard-won local autonomy of both commissioners and providers.

In order to steer a health economy through an economic downturn, there must be local negotiations. There are a host of local factors that have to be taken into account – the pattern of acute care provision, the configuration of local GP services, the maturity of practice-based commissioning (PBC) and community care provider organisations, and relationships between the health and social care commissioners, as well as the politics, demography, geography and logistics of the area. It is difficult for SHAs – and impossible for the Department of Health – to develop workable plans that must then be implemented locally.

Roles and relationships between national regulatory bodies, SHAs as the regional intermediate tier, and PCTs as local system leaders, are not as clear as they could be. A good deal has changed since the ‘new’ SHAs and PCTs were established in

2006, and some of the roles and relationships established then are no longer fit for purpose. Performance problems such as those at the Mid Staffordshire NHS Foundation Trust (Commission for Healthcare Audit and Inspection 2009) have highlighted the potential for confusion between regulation on the one hand and performance management on the other – a situation that may be further complicated if the centre takes the opportunity to intervene. Under a tight financial regime, there is a risk that performance problems may become a more frequent occurrence. The NHS cannot afford for these roles to be renegotiated during or after each and every incident.

It is not yet clear whether all PCTs have sufficient determination or skills to manage the task ahead. Local commissioning cannot be allowed to fail; where there is a need for regional intervention, it must strengthen and support the efforts of the PCT, not undermine it or try to take over.

What needs to be done?

- The role of the centre is to provide a strategic framework for the provision of health and social care, and clarity about the key priorities and the resources available to deliver them. Its focus should be on the commissioning process; its primary relationship is with commissioners rather than providers, and this should continue. It must resist the temptation to revert to a top-down, ‘command and control’ management style, not just because it lacks the necessary local knowledge, but also because to do so would prevent local leaders from using their initiative, which is the only way to drive change on the ground.
- The run-up to the election is a good opportunity for SHAs and PCTs to consider how their respective leadership roles need to be developed and reinforced, and how they will support and develop commissioning. There needs to be a much clearer understanding of the roles that SHAs, PCTs and regulators will take in the event of poor performance in service delivery. This process should be undertaken jointly by SHAs and PCTs and ‘bench tested’ to see how the arrangements might work in practice. If this is not done, there is a risk that the system will fail under the stresses that the storm will generate.
- The current period – when significant extra funding is still being pumped into the system – should be used to reinforce and strengthen commissioning. SHAs have to support PCTs by setting out a framework within which local planning can take place, including the freedoms PCTs have to make local decisions, and how implementation of these plans will be monitored. If SHAs have to intervene in local health systems, they should be very cautious about how they do so. This is a time to encourage and support local commissioners, not undermine them.

- National regulatory bodies have a role in supporting the health and social care systems to cope with the challenges ahead. Monitor should ensure that its standards for financial performance and governance requirements for foundation trusts do not hinder the development of more collaborative approaches to service delivery. As health care becomes more managed, and is provided along care pathways that cross organisational and even sectoral boundaries, the regulators may need to become more adept at taking a ‘horizontal’ view along those pathways rather than the ‘vertical’ view of single organisations. The Care Quality Commission has already indicated its ambition to achieve this – for example, through its special reviews – although in practice it will take time to adopt this approach systematically.
- Given the harsher financial climate in which commissioners and providers will soon have to operate, it is inevitable that the budgets of those who regulate the system will be reviewed. Given that the Care Quality Commission, in particular, has just emerged from a major organisational change, it may be a more fruitful approach to agree the level of regulation and inspection and how high-risk areas will be handled, rather than rushing into more rationalisation of regulator bodies at this stage.

PCTs taking a ‘system leadership’ role

The issues

The ‘system leadership’ role of PCTs is critical for the successful implementation of major service change. In the simulation, the PCT found it difficult to act as the system leader, perhaps because of the novelty of a much harsher financial climate, requiring a coherent approach to dealing with the financial challenge across the system as a whole, but also due to the complexity of balancing many conflicting perspectives and relationships. However, system leadership should not mean that PCTs get embroiled in the detailed shape of patient pathways and trying to specify exactly *how* acute, community and primary care providers integrate what they do.

There would be two dangers with such an approach. The first is that the knowledge and experience of providers would be overlooked. They understand clinical issues like managing patient risk, staff rotas, early discharges and the problems of working on extended patient pathways, and they are also better equipped to develop the managerial competence to create and maintain integrated supply chains.

The second danger is that PCTs might attempt to become the ‘director of operations’ for the local health delivery system. If this happens, then the PCT will get drawn into resolving tricky management issues between providers such as how money, risk and governance flow along the supply chains. PCTs, as world class

commissioners, are not equipped to carry this load; much of it belongs on the shoulders of the providers, and this is where it should stay.

The PCT leadership role *is* about initiating, designing and facilitating multilateral conversations between different players in the system in order to create a ‘whole system’ response to the current challenges. PCTs will have to manage a complex web of relationships, which means developing a more strategic role in brokering deals. The end result has to be real change on the ground.

If PCTs are to lead their local health systems effectively, they also need more potent levers for change than influence and negotiation. The ability to open up the market to alternative providers has been a significant lever for commissioners, even if they choose to stick with the incumbent NHS providers. Now is not the time to limit the ability of commissioners to make choices about how best to deliver care.

What needs to be done?

- Most PCTs are in the process of revising their three-year financial and service projections and are asking providers to undertake similar planning. While these are important steps, planning for the difficult times ahead requires involving everyone within the local health economy in a discussion about how the system should respond and adjust. This discussion should involve organisations from outside the NHS, including the independent and voluntary sectors, social services, and other local authority services. They should be given the opportunity to contribute their ideas for improving quality and productivity and devising ways of bringing services together.
- PCTs need to become accomplished at creating the right climate for these conversations to occur at different levels in the system and provide a forum within which they can take place. This may require some new risk-taking and diplomacy skills from chief executives and chairs.
- The ‘system leadership’ role set out in world class commissioning is not currently being performed as it should be, and will need to be strengthened. The same degree of determination applied to improving PCTs’ strategic and financial planning needs to be applied to improving their relationship management and negotiation competences. PCTs should look to strengthen the collection, interpretation and use of ‘soft’ intelligence about the views and behaviours of all the various players, and this should inform decision-making about priorities and how the resulting plans are put into practice.
- While multilateral conversations and intelligence gathering are essential to help shape an effective response to the financial challenges ahead, they are

not an end in themselves. It is the implementation of these plans – and the PCTs’ role in making real changes happen – that is the critical factor.

- Providers need to learn how to build integrated supply chains quickly. The knowledge base for this is well developed in the management literature and the necessary experience and skills are fairly common in the private sector. The role for PCTs as system leaders is in market management – brokering relationships between the potential supply chain partners, and encouraging new entrants such as voluntary sector providers where appropriate.
- In addition to system leadership and skills in market management, other aspects of commissioning that need attention include the design of referral management thresholds, decision-making in service prioritisation, and attention to the governance arrangements that underpin different approaches to commissioning.

A better understanding of the costs and benefits of local services

The issues

There are many areas that commissioners and providers could consider as opportunities for reducing expenditure and improving productivity. As part of the simulation we provided participants with a ‘coping classification’ with around 50 high-level options (see Appendix C). Ideally, the costs and benefits of each of these options need to be modelled so that the ‘easy wins’ can be identified – those that are relatively easy to introduce and have major productivity implications.

When undertaking this exercise, it will be important to be aware of what might be called the ‘gain to pain’ ratio. For example, commissioners might want to stop funding a service because they judge that it offers poor value for money and delivers little benefit. However, no matter how good the evidence may be, the presence of political resistance or the risk of losing public confidence may mean that the ‘gains’ in cost savings are not worthwhile. Without an explicit understanding of the trade-off, it is difficult for commissioners to know where to invest their efforts to bring about change.

In the past, PCTs have given relatively more attention to the allocation of growth money than to their mainstream commissioning budgets. This will inevitably change as growth money disappears, but it reflects a wider challenge. Not all PCTs have a sufficiently detailed grasp of how they spend their money – and this applies as much to the commissioning of primary care and mental health as it does to acute care. The understanding of the impact and outcomes of the commissioning budget in terms of health and health gain is not always robust. This is now a requirement (the new competency 11 in the world class commissioning

framework (Department of Health 2007)); understanding the costs and benefits of local services was important in the good times, but is crucial now.

Without this understanding, PCTs will not be in a good position to produce sound financial plans, to anticipate the consequences of reducing spend on different services, or to exert system leadership. There is a further risk that commissioners may take 'single issue' decisions in specific workstreams or service areas, leading to unintended consequences and an imbalance across the whole spectrum of care they buy.

What needs to be done?

- While there are many different ways to make savings, not all of them will accrue to commissioners. In the main, efficiencies will bring benefits to the provider side – especially under the current tariff system. PCTs need to think now about the arrangements they make with providers to ensure that productivity and demand management changes are balanced across the local health and social care economy as a whole, rather than just strengthening the financial position of individual organisations.
- An early priority for PCTs and providers is to use 'gain to pain' modelling to identify which of the options to reduce expenditure and improve efficiency and productivity they should concentrate their efforts on. This type of analysis probably has general application and it may be that PCTs could work together to share costs and reduce lead times. Similarly, there is scope to improve the usefulness of strategic needs assessments and information on the impacts and outcomes of commissioning contracts. It can take time to build up this intelligence, and SHAs could facilitate this work across their regions.
- PCTs will also need to strike a balance between working on measures that deliver savings quickly but might be painful to introduce, and those such as integrated care, prevention and health promotion that could deliver improvements in quality and productivity in the longer term. Both short- and long-term measures will be required.

Payment mechanisms need to be reformed to create incentives for efficiency across the system

The issues

While cost improvement is a permanent feature of the NHS, a period of resource scarcity on the scale and longevity projected in The King's Fund/Institute for Fiscal Studies report, *How Cold Will It Be?* (Appleby *et al* 2009), is unprecedented. No matter how stringently conventional approaches to cost improvement are applied, they will not be sufficient to deliver the level of economies required.

There is a limit to how much can be saved by doing the same things more efficiently. Also, in the NHS, cost improvements are typically sought within services and organisations, not between them – even though it is at the interface of care that the greatest efficiencies may be made.

All trusts have a requirement to achieve financial balance, but foundation trusts are required by the regulator (Monitor) to meet tougher standards that include the generation of a surplus. These requirements may act as a deterrent to ‘whole system’ working, particularly where there are several acute foundation trusts in a system, each of which is at the margins of viability. Clinical networks and partnership arrangements between providers are one option for sustaining services, but the financial deals to underpin them are not always sophisticated or robust enough.

The current incentives system is a significant barrier to the changes that will be required. It was designed to induce more activity in the acute sector and facilitate choice at a time of expanding budgets and tough targets to reduce waiting times. The incentives system encourages behaviours that run contrary to the current direction of policy, inhibits integrated care, service consolidation and redesign, rewards poor quality as well as high quality, and does not encourage or reward quality improvement when it costs money. The recent introduction of Commissioning for Quality and Innovation (CQUIN) payment incentives has done little to address this problem.

The simulation exercise showed that the current tariff-based system that is used for a significant proportion of health spending is likely to be challenged by both commissioners and providers as the financial position becomes more difficult. One option would be to set tariffs as a price ceiling below which lower prices can be negotiated, although it would be important to ensure that price competition did not lead to reductions in the quality of patient care.

The risks of price competition forcing down quality may be overstated. Although there was some evidence of this from the first simulation exercises of the internal market in the 1990s (East Anglian Regional Health Authority, Office for Public Management 1990), the NHS now has a much better understanding of the importance of quality, a much more sophisticated way of contracting for quality and not just price, and a better understanding of how costs are constructed on a service line basis.

A second option would be to average tariffs up to a volume cap, with lower prices for incremental activity above this cap (since the simulation, the Department of Health has floated this as a possibility (Gainsbury 2009)).

The centre may view tariffs as an easy lever for bearing down on costs, and indeed, previous years’ tariffs have been adjusted to reflect 4 per cent efficiency savings.

But it is unlikely that the acute sector will be able to continue to make incremental cost savings on the scale required within the current model.

What needs to be done?

- Commissioners and providers need to recognise that reducing variations in cost and quality will be vital but will not be enough to deliver the level of savings required.
- In shaping their plans, PCTs must not just focus on the acute sector – this represents only around one-half of commissioning expenditure. Primary care, community health and mental health are all likely to offer areas where commissioners can buy more for the NHS pound. A good starting point would be to focus on variations in cost and quality.
- The Department of Health has indicated its intention to make adjustments to the tariff, and clear guidance on its future development is needed. Setting the tariff as a maximum price controls costs to commissioners and creates incentives for commissioners and providers to search for economies. In one sense, the current ‘average price’ embodies current inefficiencies. Setting the tariff on a normative or best practice basis could ensure that prices reflect the most efficient practice and highest quality care. In most cases, a normative tariff would be lower than the current one.
- Tariff adjustments alone are not sufficient. There also needs to be a wider review of the current incentives system, so that incentives are more closely aligned to policy objectives, particularly the need for a radical and rapid transformation of the way services are delivered to improve productivity and release efficiency savings. The incentives need to be structured in a way that encourages rather than inhibits service redesign to improve cost and quality – even where that may run against the perceived interests of individual organisations.
- In the next year, the Department of Health also needs to review those centrally specified policies that drive up costs, over which PCTs and providers have little discretion. The centrally negotiated pay system, Agenda for Change, is an obvious candidate for review, although it is unlikely to deliver results in the short term. Redesigning and renegotiating contract and reward arrangements will take time.

Grasping opportunities to work with the independent and third sectors

The issues

Both the culture of the NHS and input-focused procurement conspire to preclude effective engagement of the independent sector. There is still a great deal of wariness, if not reluctance, over using the expertise of independent sector providers – even when they may have proven solutions to the financial and demand pressures ahead – for example, in managed care, property and estate management, and in the expertise and technology to support care closer to home.

Independent providers invest considerable time and resources trying to engage with the NHS market, but often find it difficult to get a foot in the door or even to find out which door they need to open. As one Windmill 2009 participant noted, ‘The NHS is very good at tummy tickling to make us think that we are wanted, but then there is no follow-through.’

It is clear that as the finances are tightened, NHS providers rather than commissioners may become willing partners with independent sector players if they have access to technology or capital assets that will increase efficiency and raise quality – especially if the independent sector players are prepared to risk and/or gain share.

While the extent to which the independent sector is brought into the delivery of health and social care is a matter for local commissioners to decide, the terms on which this is done require greater consistency. There has been little appetite for companies to use European Union (EU) competition law to challenge commissioners, and the extent to which this is relevant to health care remains a rather grey area. However, the NHS cannot assume that it will remain insulated from wider competition law indefinitely.

The Secretary of State for Health’s recent speech suggesting that existing NHS suppliers be given several chances to improve (Burnham 2009) does not send a positive signal to potential players from the independent or voluntary sectors and may weaken the requirement on commissioners to tender new services, though this will be clearer once the revised principles of competition are published early next year.

What needs to be done?

- The simulation provided lessons for both the NHS and the independent sector. Commissioners need to be more explicit about the problems they are trying to solve and the outcomes they are trying to achieve, rather than simply specifying the products and services they need. This approach

allows independent and voluntary sector partners to contribute ideas and innovation, especially in areas where they have specialist knowledge and expertise that may not be available in the NHS.

- Commissioners must be confident that they are entering into any tendering or contracting process with full compliance with the spirit and letter of the law on procurement and competition. The principles and guidelines set out for the Co-operation and Competition Panel provide a helpful foundation for local decision-making.
- Commissioners should treat independent sector providers fairly. However, commissioners will have justifiable concerns about the risks of destabilising established providers by moving contracts, and of non-delivery if they commission new models of care. The challenging financial environment will also require considerable collaboration within local health systems if organisations are to work together for the common good. Independent and voluntary sector suppliers should find ways to help commissioners handle some of the risks, and the challenges of implementation associated with commissioning new services.
- Both PCTs and independent and voluntary sector providers need to develop better models for risk or gain sharing. It may be worth supporting PCTs with expertise and learning in micro-market management – this could help commissioners strike the right deals with providers on risk and gain-share arrangements. There is independent sector experience to draw on here. Both the Department of Health and SHAs have a role to play in identifying and promoting good practice in these arrangements.

Clarifying and strengthening commissioning at every level

The issues

There are considerable overhead resources tied up in different forms of commissioning. As well as commissioning by PCTs, there is practice-based commissioning (PBC), joint commissioning with local authorities, pan-PCT commissioning arrangements and specialist commissioning. PCTs need to consider carefully whether commissioning decisions are being made at the right level, and what could be done to improve the effectiveness and efficiency of these arrangements to reduce duplication and to ensure that they deliver value for money.

In particular, PBC has yet to deliver all that it promised. While there are some examples of enthusiastic and entrepreneurially led PBC clusters – as was demonstrated in the simulation – the picture across the country represents considerable variation in the level of engagement (Wood and Curry 2009). Full,

100 per cent sign-up may trigger Directed Enhanced Services (DES) and Local Enhanced Services (LES) payments to practices, but does not equate to 100 per cent active involvement. In the simulation, the PBC cluster was willing to work with 'like-minded' practices but was not willing to take on responsibility for a wider population if this meant working with practices where consensus might be less easily established. As the PBC cluster pushed for 'hard' devolved budgetary responsibility, and therefore more autonomy, this left the PCT having to deal with two increasingly different commissioning roles and the potential emergence of a two-tier service within the same area.

While the Department of Health has set out a vision for PBC at national level, there are different visions of how this might be developed at local level. Also, as a recent King's Fund report noted (Curry *et al* 2008), there are inevitable differences in perspective between population-based commissioners on the one hand, and practice-based commissioners on the other.

There remain more fundamental questions about the implications of devolving real budgets. These include the scope of what can be purchased, the handling of clinical risk, the reduction in the power of the PCT to commission primary care services, and the governance, accountability and performance management arrangements that are needed – not least, to deal with the inherent conflict of interest within PBC. All of this underlines the need for more clarity about who does what, and on what terms, to ensure the most cost-effective use of commissioning resources.

At the other end of the commissioning spectrum is specialist commissioning, which takes place across many PCTs and, in some cases, across SHAs or even nationally. Investment in these service areas has been a perennial source of tension, particularly for PCTs that have financial challenges or pressing investment priorities for local services. There are risks that such tensions could be exacerbated under a tighter financial regime.

What needs to be done?

- PBC groups that can and want to undertake commissioning for their population could be given real budgets, real power and freedom to innovate. A population-based budget and a contract with clearly specified outcomes could create incentives for GPs to prevent ill health and to stop unnecessary tests, hospitalisations and treatments. Opportunities for such 'PBC+' arrangements would be welcomed – even seized upon – by many PBC consortia and more formally organised primary care organisations up and down the country. However, these arrangements do have downsides, not least the reduction in choice of provider that patients in such schemes would experience. The arrangements would need strong governance and monitoring

by PCTs to safeguard public and patient interest. Moreover, PCTs would need to consider how patients not covered by these arrangements would fare, to prevent the development of a two-tier approach.

- Before promoting these more radical arrangements, the Department of Health should commission work to bring greater clarity to the development of PBC. This should include:
 - a clearer definition of the respective roles and responsibilities of PCTs and PBC, and, in particular, whether PBC is seen as a tool for small-scale innovation, or for broader service redesign
 - a review of how and whether choice and contestability in relation to primary care and community health services is to be maintained
 - the arrangements for governance, accountability and performance management for the different models or stages of development of PBC.
- For specialist commissioning undertaken at a national, regional or sub-regional level, SHAs and PCTs need to ensure that the process is conducted with a common understanding of the financial situation in the areas served, and that there is genuine debate about the choices to be made in investment priorities. It is worth taking advantage of the current calm to bring together the ‘owners’ of these joint commissioning arrangements to make sure that the governance and decision-making structures and systems are robust enough to handle the storm.

Working more closely with local authorities

The issues

In previous periods of resource constraint, there have been complaints of ‘cost-shunting’ across the health and social care divide, in both directions. A common source of tension is where hospitals have had to carry extra costs arising from delayed patient discharges due to the unavailability of social care services. Changes to health service delivery patterns could put additional pressure on social care services, and vice versa. Close communication between the relevant health and social care organisations will be essential, both in relation to operational matters and to developing plans for responding to the budget constraints.

Simulation participants saw significant opportunities for integration, both in commissioning (especially for older people and mental health) and service provision (community health services, social care and mental health). But delivering these benefits for patients and to improve productivity takes time. While it is tempting for PCTs to look at structural integration of health and social care commissioning, this may not be essential and may entail risks. Social care

is just one element of local authority responsibility and competes with other spending priorities – though it remains one of the most important of the local authority functions.

A further risk to health and social care relations is the different directions in which commissioning and service delivery are heading. There are two key differences. First, most social care is delivered by independent and third sector providers, who have made greater use of procurement than in the NHS. Second, within social care, the ‘personalisation’ agenda is aimed at reshaping the pattern of care delivery and will have implications for the way that commissioning is done.

There is a risk that, in response to the prospect of a tighter financial regime – and as occurred in the simulation – health care commissioners will go in the opposite direction to their social care colleagues – resistance to independent sector involvement and limiting patient choice. Such differences in style and response may inhibit effective joint working.

Personalisation and choice need not be incompatible with higher productivity, and there are lessons for the health sector in the approaches that local authorities take to procurement and market management, without losing sight of the size and complexity of commissioning health services.

What needs to be done?

- Central government could decide to align health and social care commissioning cycles, which would enable local collaboration. This would provide time and an incentive for both parties to agree their priorities, and discuss actions that might affect each other’s spending, before the yearly commissioning intentions/plan is published. Local authorities and PCTs need to keep each other informed about their commissioning strategies, plans and approaches and look at areas where they can work together either in direct commissioning of care pathways or around market management and procurement opportunities.
- PCTs need to have good working relationships with different parts of the local authority structure. Relationships with the politicians in the local authority cabinet and on the scrutiny committee are likely to be particularly critical during the next few years. Politicians would probably welcome an early briefing about future funding constraints and the implications for both health and social care services.
- There are lessons in the approaches that some local authorities take to procurement and market management that could be applied to health care.

- Responding to the tighter financial regime may be a catalyst for bold, ‘joined-up’ responses that go beyond the links between health and social care; education, community safety, leisure and job centres all have a part to play in strengthening community capacity to cope with recession. Their resources should be used and combined with health spend in more efficient and productive ways.
- Personal budgets and the piloting of direct payments for health care should be used as an opportunity to test whether personal care planning, together with devolved financial responsibility to individuals, leads to more effective use of resources and greater patient satisfaction. The pilots should also explore the potential benefits to be gained from integrating health and social care budgets.

Utilising estate rationalisation and technology for productivity and quality gains

The issues

The Department of Health’s transforming community services programme makes it clear that there are real productivity gains to be made in this sector (Department of Health 2009b). However, in some PCTs, community health services have been underfunded or have been seen by the PCT as a source of easy savings. A recent survey by the *Health Service Journal* found that spending on community services varies from under £100 to over £200 per head of population – a range that is unlikely to be explained by variances in need, demography or costs alone (Crump 2009).

Most PCT commissioning strategies include a commitment to shift from a pattern of care reliant on hospitals to one where more services are provided in or near patients’ homes. The prospect of securing ‘more for less’ by localising services is attractive to commissioners as it meets two goals: reducing costs while improving the patient experience. However, savings and quality improvements from radical pathway redesign have not been easy to realise. They are dependent on careful management, the development of integrated supply chains and new ways to incentivise providers. This is one area where competition may encourage new suppliers with a range of products and approaches that can support community- and home-based care.

However, it is no good taking care out of hospitals if it leaves behind ‘stranded costs’ – both from staffing and infrastructure. If these are not removed from the system and savings passed back to the commissioners as the price for maintaining the supply of other services, care closer to home will cost more than the current pattern of hospital-based care.

There may be scope for rationalising the health care estate across primary, community and mental health services to create an opportunity to both improve the quality of the built environment and reduce maintenance costs and liabilities. If considered alongside other public services, there may be real scope for innovation in the way that existing buildings are used to deliver care and support to local communities. But the savings to be gained from site disposals will not necessarily benefit the whole health care system unless the process is carefully managed.

Private finance initiative (PFI) schemes present a particularly difficult constraint to the flexibility of health care providers to respond to shifts in demand by limiting changes in the configuration or use of estate. Typically, these contracts are relatively rigid and long term, but this need not mean that they cannot be renegotiated.

What needs to be done?

- Having put their community services at ‘arm’s length’, PCTs need to take the next step and assertively commission community-based health care, encouraging a range of bidders to compete either for or within the market. Even if some efficiency gains were possible, maintaining the current pattern of provision is unlikely to deliver the scale of savings that are needed.
- At the moment, there is little firm evidence that care closer to home is cheaper than hospital-based care (although there may be some quality benefits). It would be useful if an authoritative study were undertaken to show how the benefits – including the reduction of costs in acute hospitals – could be derived. This would need to recognise that changes in the way care is delivered should be system-wide.
- PCTs need to pay careful attention to building financial and performance incentives into their contracts with acute care providers, to facilitate both a shift of care to community settings and reductions in hospital infrastructure costs. SHAs can help by sharing information across their regions about the different approaches that are available and their relative effectiveness. Vertical integration of providers is one possible solution but this has other costs and risks. Simple changes to tariff may allow these changes to be realised more quickly, and encourage acute providers to work actively with community providers to reduce hospital admissions.
- Community service providers are starting to behave in a more commercial way, but they must realise that their future success lies in reinventing the model of community- and home-based care. They need to look at ways of forming supply chains with other providers. They should also explore

opportunities for partnerships with independent providers that can offer either complementary services or enhanced management systems, or extend the reach of the organisation beyond the local market.

- For the most part, social care provision is delivered by commercial and third sector organisations. Some of the larger and more innovative providers might offer ways of supporting cost-effective patient care closer to home. While there may be opportunities to secure contracts with NHS commissioners or through joint commissioning arrangements, they should also consider what benefits they could offer acute providers. NHS providers need to access appropriate expertise to ensure that any joint ventures they embark on are beneficial to both parties and ultimately ensure better value for money and higher-quality patient care.
- PCTs need to co-ordinate an integrated estates review for out-of-hospital care across the local economy. This needs to be developed in an imaginative way and should consider all options that could release revenue to invest in patient care elsewhere. The opportunities for estates efficiency gains could be explored on a much larger scale than the NHS alone; links with schools, colleges and universities and other public services could offer interesting possibilities that could yield wider benefits. Most PCTs will not have the in-house skills or capacity to handle the level of analysis required, but this could be developed by SHAs for use on a regional basis and/or commissioned from a commercial supplier.
- Health care providers that are coping with the constraints of PFI funding need to consider either renegotiating the terms of the contract or potentially buying out the contracts using alternative sources of borrowing. While there may be financial penalties for early settlement in the current financial climate, these terms could be renegotiated, and the flexibility that the changes offer may well be worth the price.

Engaging the public and patients in the process of change

The issues

Maintaining public and patient commitment to the NHS while managing tighter budgets and rising demand will be a delicate balancing act. The NHS has huge public support but this could evaporate rapidly if financial pressures are seen to be directly cutting services or damaging patient care. The public may also have little tolerance of commissioners or providers who have not seized opportunities to reduce expenditure and waste.

A financial 'crisis' (as it may well be portrayed in the media) is not the time to neglect public, patient and staff engagement. Their support may be critical to the

ability of the NHS to deliver quality with fewer resources – and they will all be able to contribute ideas about how best to cope with the changes.

These conversations will not be easy. Quality, from the patient's perspective, tends to focus on the experience of treatment and care, whereas for commissioners and providers, quality embraces both clinical effectiveness (which patients usually take on trust) and cost-effectiveness (which is a theoretical concern for taxpayers but is not usually a significant factor in the public's views about specific service changes). These conversations may well prove to be even more difficult given the implications of the NHS Constitution and recent ministerial speeches about patients' rights and entitlements.

A further challenge is that the constraints on the NHS budget may not be aligned with those in the wider economy. The country is currently in the grip of a recession but starting to see glimpses of recovery. The full impact of the government's massive borrowing will become clearer just as the economy starts to recover. The juxtaposition of these trends may make it more difficult for the public to understand the need for cuts in local health services.

PCTs will need to be honest and explicit about the resources at their disposal, the consequences of different options, and what will happen if decisions are not taken in a timely way. The scale of the changes will require tough decisions and some groups may be disadvantaged by the choices that are made. It is unrealistic, therefore, to expect a complete consensus on the way forward, but this should not deter efforts to gain as much agreement as possible.

For their part, patient representative bodies that engage in these debates will find themselves with little influence if they are not prepared to recognise the new financial context or if local commissioners are not open with them about the scale of the challenge. The simulation showed that those who only wanted to talk about better quality and access, refusing to get involved in discussions about the difficult options for achieving financial savings, found themselves progressively marginalised or excluded from local planning processes.

What needs to be done?

- As the NHS prepares for the change in its financial fortunes, commissioners and providers must engage the public, patients, staff, local authority officers and members, third sector partners and public representatives in meaningful conversations about the future. This has been talked about for many years, but what is being suggested here is a significant step change in activity.
- Some PCTs have already embarked on this process but all of them will need to. The process should go way beyond the narrow conventions of NHS public consultation. Instead, it should be a deliberative and continuing process at

the front end of the commissioning cycle, rather than the last act before a contract is let. Failure to go through this process will dramatically reduce the ability of managers and clinicians to implement sustainable changes. Given that NHS spending is probably protected until 2011, there is an opportunity to start these conversations now and prepare patients and the public for what is to come.

- PCTs should strengthen their capacity to collect, interpret and use 'soft' intelligence data about the views, attitudes and behaviours of all those with an interest in their work. This will prove important in managing whole system relationships and will be crucial in putting plans into practice.
- PCTs may need to work together to co-ordinate their engagement efforts if issues cross their boundaries. They will have to ensure consistent messages about what needs to be done, by whom, and by when. Public confidence will be undermined if commissioners and providers do not present a united front, or if there are differences between PCTs working in the same local health economy.

Engaging staff and considering all options to improve workforce productivity

The issues

The workforce represents over 70 per cent of NHS provider costs. Engaging staff and staff representatives therefore has to be an important part of the planning process for 'the storm scenario'. But there are real risks that this will be done through vague assurances or commitments that cannot be kept. The challenge for managers at local level will be to inspire and motivate staff at a time when personal futures are challenged by the inevitable uncertainty that accompanies organisational and service delivery changes, and there are few prospects of increasing financial reward.

Productivity improvements must mean fewer staff providing more services per staff member – an obvious point, but one that is not always widely acknowledged. Both Labour and Conservative politicians have indicated an intention to impose pay freezes across the public sector. At a time of low inflation, however, pay restraint is unlikely to result in significant real terms cuts in pay.

There is a trade-off to be made between protecting numbers of staff and pay – greater pay restraint would reduce the need for dramatic cuts in staff numbers. Agenda for Change, which has generated significant increases in the wage bill without commensurate increases in productivity, is a constraint that needs addressing.

Any changes that are made to the shape of the workforce and to terms and conditions will need to be handled well to avoid a return to the old confrontational style of employee relations. Many of the current generation of human resources (HR) managers have only worked through a period of relatively harmonious relationships, and may be unprepared for more difficult negotiations.

What needs to be done?

- As the expenditure cuts start to hit public services there is a need for even stronger partnerships and engagement with the unions and staff representatives at national, regional and local levels.
- Foundation trusts need to use their freedoms to greatest benefit. This may involve pay restraint or more innovative ways of rewarding staff and linking that to productivity – a self-financing carrot to positive change. Pensions and national pay awards will have to be reviewed and determined by the Department of Health. These are unlikely to yield any short-term savings, but need to be put on a more sustainable basis for the future.
- Making redundancies in order to reduce the size of the workforce or to change the skill mix typically entails costs in the short term. During the next year, NHS employers need to consider taking forward any re-profiling of their workforce while they have more flexibility in their funding position.
- Health care employers need to ensure that their HR managers are equipped with the necessary skills to manage workforce changes and establish productive partnerships with staff representatives. Even greater care needs to be paid to demonstrating good people management during these difficult times.
- For their part, the trade unions have a difficult path to tread between principle and practice. Opposing workforce changes such as pay freezes or changes in reward arrangements may be the normal way to protect their members' interests, but, depending on the local context, employees may find such changes preferable to the alternative of fewer jobs.
- While most workforce issues are a matter for providers, workforce planning and support for productivity is a system-wide issue in which PCTs and SHAs play active roles, not least through their commissioning of education and training. PCTs must also assure themselves that any workforce productivity improvements made by providers offer sufficient safeguards for patient safety and quality.
- There needs to be a renewed focus on workforce redesign. There has been much discussion over the past few years about the shape of the workforce

needed to deliver national plans and strategies – the shift to care closer to home being a good example. Health care providers need to improve their capacity to realise these changes, making the shift from the current workforce profile to new, more flexible and productive arrangements.

- This requires a complex blend of skills and knowledge, including: an appreciation of the rules and guidelines that underpin the practice of different professional groups; imagination in the design of alternative contractual terms and conditions; the ability to design performance and productivity expectations for different roles; the ability to coach, motivate and encourage health care staff to make the necessary changes; and financial modelling to explore the transitional and ongoing cost implications of different options.

Recommendations

Windmill 2009 provided little confidence that the cushion of recent significant funding increases enjoyed by the health sector has put it in a strong position to weather the coming 'storm'. As one participant commented, 'NHS commissioning is currently a transaction where people who don't know what they are buying, buy from people who don't know what they are selling, or what those services deliver for consumers.'

Tough decisions will be needed, but unless they are based on sound information about the benefits, consequences and timescales involved, it is possible that good intentions to weather the storm will simply prolong the pain.

Despite this somewhat gloomy conclusion, the change in the health system's financial fortunes does present opportunities. The Obama administration's mantra – 'Don't waste a good crisis' – should be taken to heart. The 'storm', if managed appropriately, could well be the catalyst to making the bold and brave shifts in service configuration that have been discussed for years but which have not materialised. It could also be an opportunity to drive through changes in workforce patterns that have similarly lagged behind the system's understanding of what it needs to deliver care in the future.

The previous section of this report lists our recommendations for action against the 11 key themes that were identified during Windmill 2009. We summarise the most important of these below.

Department of Health

- National leaders should be explicit about the scale of the financial challenges ahead and realistic about the limitations of conventional cost improvement measures. It is vital that ministers help to create a climate that enables local leaders to engage meaningfully with their public and staff over the more radical measures that are likely to be necessary.
- The centre must resist the temptation to revert to a top-down, 'command and control' management style. Instead, it should provide clear strategic leadership that will empower local leaders to use their initiative and negotiating skills to achieve the best solutions for providing quality care with the resources available.
- The Department of Health should commission an urgent review of incentives, particularly payment by results, to ensure they are more closely

aligned to the need for a radical and rapid transformation of the way services are delivered, to improve productivity and release efficiency savings.

- The Department should resist reining back on market forces, since these could deliver the 'edge' and innovation needed to achieve the necessary changes. There needs to be a more carefully considered balance between collaboration and competition.
- The Department should commission work to bring greater clarity to the development of practice-based commissioning (PBC). This should include a clearer definition of the respective roles and responsibilities of primary care trusts (PCTs) and PBC, the role of choice and contestability, and the arrangements for governance, accountability and performance management for the different models or stages of development of PBC.
- The Department should urgently commission research to show how the benefits of care closer to home – including the reduction of costs in acute hospitals – could be derived, recognising that changes in the way care is delivered need to be system-wide.

There are also some actions that need to be initiated now, but may take longer to produce results.

- The Department of Health should seek agreement on an alignment of health and social care commissioning cycles to enable more effective local collaboration on forward plans.
- The Department should initiate a review of Agenda for Change to ensure that increases in pay are more closely tied to commensurate increases in productivity.

The regulators

- National regulatory bodies have a role to play in supporting the health and social care systems to cope with the challenges ahead, even where this appears to act against the perceived interests of individual organisations.
- Regulators need to reconsider the interface between their respective responsibilities. They need to develop better methods of regulating patient pathways and supply chains, rather than simply regulating organisations.
- Together with strategic health authorities (SHAs), regulators need to agree their respective roles, especially in relation to handling poor performance and significant financial or quality failures.

Strategic health authorities

- SHAs and PCTs need to consider how their respective leadership roles should be developed and reinforced. They also need to agree with the regulatory bodies who does what in terms of handling poor performance and significant financial or quality failures, before specific cases arise.
- SHAs must support PCTs to become real ‘system leaders’, yet resist the temptation to take over their role, or revert to a ‘command and control’ management style that might pre-empt locally negotiated solutions.
- SHAs need to ensure that the specialist commissioning process is conducted with a common understanding of the financial situation in the areas served, and that there is genuine debate with local PCTs about the choices to be made in investment priorities.

Commissioners

- PCTs need to start engaging staff and other local organisations and interested parties in preparing realistic plans now. If necessary – in the absence of firm and detailed forward-funding prospects – they should base these plans on what might appear to be ‘pessimistic’ assumptions.
- In preparing these plans, PCTs need to recognise and act on their role as system leaders. They should involve everyone within the local health economy, including local authorities and the independent and voluntary sectors, to determine how the system as a whole should respond and adjust to the future funding prospects.
- In shaping their plans, PCTs must not only pay attention to the acute sector. Primary care, community health and mental health are all likely to offer areas where commissioners can secure more for the NHS pound.
- PCTs need to ensure that savings from productivity and demand management changes are reinvested across the health and social care economy as a whole on the basis of agreed priorities, rather than simply strengthening the financial position of individual organisations.
- Commissioners will also need to strike a balance between working on measures that deliver savings quickly, and those such as integrated care, prevention and health promotion, that are more likely to deliver improvements in quality and productivity in the longer term.
- Commissioners should not overlook the contribution that the independent and voluntary sectors could make – especially where they have proven solutions for handling the financial and demand pressures the system will

face – for example, in managed care, property and estate management, and in the expertise and technology to support care closer to home.

- PCTs need to co-ordinate an integrated estates review for out-of-hospital care across the local economy. This needs to be developed in an imaginative way, and should consider all options that could release revenue to invest in patient care elsewhere.

Health care providers

- All providers need to play their part in responding constructively to system-wide development plans, even where these might appear to run counter to their individual organisational interests.
- Community service providers need to recognise that their future success lies in reinventing the model of community- and home-based care. They need to look at ways of forming supply chains with other providers, and explore opportunities for partnerships with independent and voluntary sector partners where these could improve the quality, cost-effectiveness and range of services they offer.
- As the NHS prepares for the change in its financial fortunes, providers must engage the public, patients, staff, local authority officers and members, third sector partners and public representatives in meaningful conversations about the future.

Appendix A: Windmill 2009 participants

Anna Anderson	Finance Director, Homerton University Hospital NHS Foundation Trust
John Appleby	Chief Economist, The King's Fund
Rebecca Ashton	Advisor to the Chief Executive, The King's Fund
Neil Bacon	Founder, iWantGreatCare
Carol Black	National Director for Health and Work, Department for Work and Pensions
Steven Bolam	Finance Director, Basingstoke and North Hampshire NHS Foundation Trust
Derek Bray	Chief Executive, NHS Derbyshire
Elizabeth Buggins	Chair, NHS West Midlands
Conor Burke	Medical Director, Redbridge Primary Care Trust
Iain Cameron	Head of the School of Medicine, University of Southampton
John Coakley	Medical Director, Homerton University Hospital NHS Foundation Trust
Victoria Corbishley	Policy Advisor, Monitor
Phil Cowley	Chief Executive, Care Partners Trust
Penny Dash	Vice Chair, Board of Trustees, The King's Fund
Angela Dawe	Chief Operating Officer, Lambeth Community Health
Peter Devlin	Clinical Director, Brighton Integrated Care Service
Niall Dickson	Chief Executive, The King's Fund
Anna Dixon	Director of Policy, The King's Fund
Ian Dodge	Director of Policy Support Unit, Department of Health
Margaret Edwards	National Director of Productivity and Efficiency, NHS London
Alan Gavurin	Head of Strategic Development, Assura Group Limited
Malte Gerhold	Deputy Director, Strategy Group, Department of Health
Mike Gill	Medical Director, Newham University Hospital NHS Trust
Ian Gilmore	President, Royal College of Physicians
Steve Godecharle	RCN London Region
Diane Gray	Director of Strategy and Planning / Deputy Director of Public Health, NHS Milton Keynes
John Hall	Strategy Director, Department of Health
Robert Harris	Director of Policy, Monitor
Mark Hendy	Group Strategy Manager, BUPA

Stephanie Hood	Director of Communications and Engagement, NHS South East Coast
Candace Imison	Deputy Director, Policy, The King's Fund
Diana Jakubowska	Head of Communications, Cambridgeshire and Peterborough NHS Foundation Trust
Mark Jennings	Director of Health Care Improvement, The King's Fund
Justin Jewitt	Chairman, Home Choice Care Ltd
Andrew Jones	Group Medical Director, Nuffield Health
Ron Kerr	Chief Executive, Guy's & St Thomas' NHS Foundation Trust
Martin Land	Leadership Associate, The King's Fund
Peter Lees	Medical Director, NHS South Central
Karen Lynas	Director of Leadership, The King's Fund
Vince McCabe	Chief Operating Officer, West Essex PCT
Martin McShane	Director of Strategic Planning and Health Outcomes, NHS Lincolnshire
Vivienne McVey	Medical Director, Assura Group Limited
Caro Millington	Ex-NHS Chair and Artist
David Mobbs	Chief Executive, Nuffield Health
Gary Needle	Director of Methods, Care Quality Commission
Jenny Owen	Executive Director, Essex County Council
Elisabeth Paice	Dean Director, London Deanery
Edward Palfrey	Medical Director, Frimley Park Hospital NHS Foundation Trust
Keith Palmer	Chair, Barts and The London NHS Trust
Nik Patten	Chief Executive, Peterborough and Stamford Hospitals NHS Foundation Trust
Michael Phillips	Member of Patient/Carer Network, Royal College of Physicians
Andrew Price	Business Development Director, Vanguard Healthcare
Rob Prince	Sales Director, EMEA, Intel
Helena Reeves	Communications Director, NHS Surrey
Tim Richardson	GP, Integrated Care Partnership and Epsom Day Surgery
Bob Ricketts	Director of System Management and New Enterprise, Department of Health
Alan Rosenbach	Head of Strategy and Innovation, Care Quality Commission
Shahid Sardar	Patient and Public Involvement Manager, NHS Newham
Liz Saunders	Consultant, Leadership Development, The King's Fund
Marcia Saunders	Chair, Brent Teaching PCT
Michael Sharon	Director of Solutions, United Health UK
Bill Shields	Director of Finance and Performance, South West Strategic Health Authority
Graham Simpson	Director of Strategy, Barts and The London NHS Trust

Sue Slipman	Director, Foundation Trust Network, NHS Confederation
David Smith	Chief Executive, Kingston PCT
Richard Smith	Director, UnitedHealth Chronic Disease Initiative
Jan Sobieraj	Chief Executive, NHS Sheffield
Julie Waldron	Chief Executive, Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust
Katherine Ward	Director of Commissioning and Consulting, UnitedHealth UK
Lynne Watson	Director of Personnel and Development, Luton and Dunstable Hospital NHS Foundation Trust
Paul Watson	Director of Commissioning, NHS East of England
Lyn Whitfield	Freelance Journalist, Editor and Project Manager
Matthew Winn	Managing Director, Cambridgeshire Community Services

Design Team

Sarah Harvey	Director, Loop2
Alasdair Liddell	Senior Associate, The King's Fund
Laurie McMahon	Senior Associate, The King's Fund, and Director, Loop2

Appendix B: Policy options used in 'the storm scenario' round two

For the second round of 'the storm scenario', we introduced the health and social care 'emergency strategy committee' (ESC). At its first meeting, the ESC asked for a 'no holds barred' appraisal of the range of interventions and freedoms that could be considered to help the NHS and its social care partners adjust to the changed financial environment and deliver improvements in care and support to citizens. This programme has been given the working title 'Project Phoenix'.

A leaked memo from the Department of Health outlined a long list of possibilities for the ESC to consider. An excerpt from the proposals is given below.

Proposal 1: Abolish primary care trusts and franchise health maintenance and delivery

Rationale

There have been repeated attempts to improve the quality and effectiveness of commissioning and the results have been somewhat disappointing. On average, primary care trusts (PCTs) cost the taxpayer around £20 per person per year in management costs; across the country this amounts to around £1.2 billion. The costs of the purchaser-provider split are actually much higher when the costs of transactions and differing regulatory methods are taken into account.

The concept

This proposal would replace PCT commissioning with franchises. The franchises would be contestable on a five-year basis and offered to supply chains – primary and community services, acute care and mental health – that would bid to provide health improvement and health care for a defined population. There would be a national maximum per capita bid price; bidders would be competing for the best offer at the best price. The approach provides an incentive to keep people healthy and reduce demand for the most costly health care. The economic regulator would determine annual uplifts and provide benchmark data on productivity and efficiency.

Proposal 2: Lift restrictions on the location of primary medical and pharmacy businesses and on professional demarcations

Rationale

General medical and pharmacy contracts are arguably anti-competitive. There are restrictions on who can employ whom and on who can set up a business in a local area.

The concept

By removing these restrictions, there is the opportunity for new providers to enter local markets. This competition could help to drive out inefficient businesses. Patients could access integrated medical and pharmacy services and providers would have flexibility to make better use of the clinical skills of pharmacists.

Proposal 3: Increase the range of medicines available over the counter

Rationale

Pharmaceuticals expenditure has been growing at an alarming rate. Across most of the Western world, people can access a wide range of over-the-counter medicines directly with support from pharmacy advisors. If we extend the range of over-the-counter medicines, more people will go directly to pharmacies and may be willing to buy basic medicines directly rather than on prescription.

The concept

A list of medicines that are relatively safe but which cost more than the price paid by individuals on prescription should be drawn up and made available over the counter. Fierce competition from Internet suppliers would be expected, and so in the medium term, may reduce costs to consumers.

Proposal 4: Allow PCTs to suspend GP contracts where quality and productivity fall below minimum thresholds

Rationale

Currently, PCTs have few levers for weeding out inefficient primary care practices unless the partners in a practice decide to retire. Combined with opportunities for greater competition in primary care, this could drive major improvements in use of resources.

The concept

There would be a nationally specified efficiency threshold that would be negotiated with the British Medical Association (BMA). There would be no transitional support for affected practices. This would provide an incentive for small or inefficient practices to seek collaborative arrangements or takeovers.

Proposal 5: Commission all primary care

Rationale

The current arrangements have evolved over time and include a number of perverse incentives. Allowing PCTs the opportunity to zero base primary care contracts would offer the opportunity to target local health priorities and tailor local performance incentives.

The concept

PCTs would be able to tender for the provision of primary care for part or all of their area. They would put together service specifications and identify outcome measures, and then performance manage the successful providers.

Proposal 6: Allow practice-based commissioning groups to take on real budgets

Rationale

The current system of PBC contains too many hurdles or 'gateways' for GPs to make quick responses to observed weaknesses in their patients' care. PBC groups can also overspend without any real consequences.

The concept

Groups of practices could take on a real budget for a specified patient population. Rules would prevent them from excluding high-risk or high-cost patients. Practices would have to demonstrate that they were sufficiently strong business organisations with actuarial skills. The practices would take on a real risk but could keep and reinvest any savings. The practices would be given a new contract and would have to resign from their General Medical Services (GMS)/Personal Medical Services (PMS) arrangements.

Proposal 7: Introduce charges and co-payments

Rationale

Currently, there are no disincentives to people using health services inappropriately. A small number of symbolic charges could help to shift attitudes and behaviours, and co-payments would provide an income stream to providers as well as reduce costs to the state. A safety net might be included for the less well off.

The concept

Areas where charges could be considered include: a) first GP appointments; b) outpatient appointments where patients fail to attend (if they have not previously notified the provider); and c) inappropriate patient requests for ambulance services. Co-payments might be sought for: a) hospital meals; b) single rooms; c) more expensive drugs; and d) faster and more flexible appointment times.

Proposal 8: Allowing commercial sponsorship of health care provision

Rationale

This could allow additional income to flow into the NHS and, if well managed, could enhance the brand of health and health care, particularly to younger people.

The concept

Sponsorship schemes would be locally negotiated and managed. Some minimal but common sense restrictions would be put in place to protect the reputation of the NHS. For example, tobacco or alcohol sponsorship would not be allowed.

Proposal 9: Allowing foundation trusts to become fully commercial

Rationale

Foundation trusts have long complained that they are treated as part of a nationalised industry rather than as competitive businesses. Given greater freedom, foundation trusts would be able to realise their commercial potential and invest surpluses in better patient care.

The concept

Restrictions that would need to be removed include opportunities to establish commercial or joint ventures, and the private income cap. Mergers and acquisitions would be facilitated by regulators whenever this was judged to be in the public interest. Vertical integration through managed supply chains would be encouraged.

Proposal 10: Changing governance arrangements

Rationale

Considerable sums are tied up in payments for non-executive directors and members of PCT professional executive committees (PECs). Does this represent good value for money?

The concept

A range of options could be considered here, including: a) abolishing PECs; b) reducing the size of trust boards (eg, chief executive officers (CEOs), finance and medical directors, plus chair and two non-executive directors); c) reducing the number of PCTs so they cover a minimum size of 1 million people; and d) making strategic health authorities (SHAs) government offices and removing their boards.

Proposal 11: Changing the retirement age

Rationale

Raising the retirement age would reduce NHS pension liabilities.

The concept

The retirement age would be raised to 70. Earlier retirements would be allowed, with a corresponding reduction in pension entitlements.

Proposal 12: Pay and reward changes

Rationale

Senior managers and clinicians are now paid significantly more than their equivalents in the private sector; there is an opportunity to recalibrate reward.

The concept

Agenda for Change would be frozen. National rates of pay for senior managers and consultants would be capped until they fall in line with private sector salaries, but local negotiations would be allowed. Non-financial rewards could also be capped or scrapped – for example, car allowances, leave allowances, car parking. An alternative would be to replace part of consultants' salaries with productivity payments, which are triggered by specified levels of activity and quality.

Proposal 13: Effectiveness filters for treatment

Rationale

Some procedures have limited value for certain categories of patients but these indicators are rarely made explicit. Effectiveness filters would allow treatments to be rationed and funding directed to patients with greatest potential to benefit.

The concept

Effectiveness filters/protocols would be specified nationally, regionally or locally. They would be well publicised and could be defined to incentivise healthy lifestyles. NICE (the National Institute for Health and Clinical Excellence) could be asked to bring forward guidelines for disinvestment for procedures that offer marginal benefits.

Proposal 14: Make the tariff a maximum and allow price competition

Rationale

Payment by Results (PbR) incentivises providers to over-treat patients and manipulate clinical coding. Allowing price competition would enable commissioners to negotiate best-value contracts that reward the right things.

The concept

National reference costs would continue to be published to inform decision-making. Commissioners and providers would be encouraged to design local incentive systems that reward appropriate treatment, and positive patient experience and outcomes.

Proposal 15: Introduce a national, open access, online talking therapy service

Rationale

Demand for talking therapies is escalating as a result of the recession, yet there are long waiting times for treatment in many areas. This proposal would dramatically reduce the costs of care and access to care for low-level mental illness, and could prevent further deterioration and progression to somatic disease.

The concept

Individuals would access the online talking therapy service as and when they needed it, either directly or via GP referral. The website could include a range of self-help tools as well as direct dialogue with therapy and counselling professionals.

Proposal 16: Promote health tourism

Rationale

There are a number of elective procedures that are available in Europe at a price significantly below what they cost the NHS and independent providers in England. Health tourism is becoming more common.

The concept

Commissioners would be encouraged to think about health tourism opportunities for dental care, plastic surgery and a range of orthopaedic procedures. Patients would not have to pay up front, and all travel costs would be funded.

Proposal 17: Renege on previously agreed rights to treatment

Rationale

The NHS Constitution and the rights to NICE-approved drugs have largely benefited the better-off socio-economic groups who are informed about their entitlements, which has contributed to greater health inequalities. The costs of NICE-approved drugs are becoming prohibitive for many PCTs.

The concept

All NICE assessments would be for guidance to PCTs and providers rather than mandatory.

Proposal 18: Induce a large-scale sale of NHS estate

Rationale

Sale and leaseback of the capital assets will provide the Treasury with a receipt that would offset PbR, with no direct effect on patient care.

The concept

Foundation trusts and PCTs would be forced to sell land and buildings through a nationally managed scheme.

Proposal 19: Remove public consultation requirements for proposals involving major service change

Rationale

The health and social care system needs to be more nimble in identifying opportunities for improved productivity and implementing them. Public consultation can block innovation and can be costly.

The concept

Legal requirements to consult with the public would be removed. There would be an expectation that public and patient engagement would continue.

Proposal 20: Becoming a model employer

Rationale

At 4.5 per cent, the average sickness absence rate in the NHS is 50 per cent higher than the private sector. If the NHS could improve its sickness absence rate in line with private sector levels, it would save £1 billion a year.

The concept

An employee wellness programme for NHS and local authority staff would be introduced. This would cost money in the short term but reap benefits in the longer term. Independent sector operators may wish to develop joint ventures. Managers would be trained in effective absence management processes.

Appendix C: The coping classification: approaches to reducing costs, improving efficiency and increasing income

Please note: this paper outlines **possible** options that could be used to tackle cost reductions or income enhancement. Whether these options are effective in delivering these results and the impact they will have on service users will depend on the methods used and how they are implemented in local settings. The wrong scheme, or an application that is insensitive to context, could deliver outcomes that are the opposite of what was intended and/or lead to a worsening experience or outcomes for patients.

The classification is designed to help structure debate rather than offering a comprehensive description of all approaches to improved efficiency. The headings have been kept generic in order to provide a common language for debate – there will be specific methods that could be used to reduce costs and/or improve efficiency for each option. Some options can lead to one-off savings; others will yield recurrent savings if properly managed. Not all will deliver significant levels of savings. The classification covers seven headings.

1. Organisation and management options (Commissioner and provider)



2. Demand management options



3. Limiting access to care

Set risk exclusions for specific treatments	Exclude specified treatments or services from NHS funding	Keep waiting times at target levels but no lower	Restrict payments of patient transport cost	Restrict range of providers or pathway choices	Exclude high-cost treatments where cheaper alternatives exist
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4. Service supply and delivery: clinical productivity

Reduce lengths of stay	Increase day surgery rates	Reduce pre-op bed days	Reduce number of routine outpatient follow-ups	Reduce number of routine outpatient follow-ups	Run facilities 24/7 or extended periods	Consistent use of generic drugs and products	Use medicines management to reduce waste
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5. Service supply and delivery: infrastructure productivity

Outsource/re-tender support services, eg, linen	Share laboratory/diagnostic kit with other providers	Manage supply chain to reduce duplication	Shift location of care to cheaper facilities	Sell/rent land or buildings	Use lean processes and manage variation	Cut non-productive service lines	Cut non-productive service lines
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6. Income enhancement

Establish joint ventures to increase private income	Increase income from charges, eg, for car parking and hospitality	Improve fee recovery, eg, insurance companies, overseas patients	Improve treasury management and investment	Sell education, research and services to overseas buyers	Increase retail income generation	Extend range of means tested co-payments and charges
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7. Workforce productivity

Change skill mix within professions	Align workforce to demand fluctuations	Reduce absenteeism	Tackle impaired work performance (presenteeism)	Reduce agency costs	Cut/freeze pay and/or pensions	Redesign workforce for specific clinical pathways
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